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ABSTRACT

Papers from a 1981 conference on curriculum for health planning, policy, and marketing and from a 1982 conference on curriculum for strategic planning are presented. Responses to the papers and summaries of the proceedings are also presented. Titles and authors are as follows: "A Curriculum in Community Health Planning: An Approach for Today and the Future" (Henrik L. Blum, Christopher Bellavita); "Teaching Planning Methods with a Contingency Framework" (Paul C. Nutt); "Curriculum in Institutional Planning for Programs in Health Administration" (Roger Kropf); "A Marketing Curriculum for Health Services Administration" (R. E. Scott MacStravic); "Integrating Policy, Planning and Marketing in the Curriculum for Health Services Administrators" (Philip N. Reeves); "Problem Definition and the Strategic Planning Process for Hospital and Health Services Organizations" (David E. Berry); "Environmental Scanning and Boundary Spanning as External Value Determination Mechanisms" (Andrew A. Lasser); "Developing a Strategic Plan" (Roberta N. Clark); and "Plan Implementation" (Robert C. Myrtle). (SW)

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# CURRICULA FOR HEALTH PLANNING POLICY AND MARKETING:

## Conference Papers 1981–1982

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The Association of University Programs
in Health Administration

In cooperation with

The Department of Health Services Administration
The George Washington University

and

The Society for Hospital Planning
of the American Hospital Association

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# CURRICULA FOR HEALTH PLANNING, POLICY AND MARKETING:

# CONFERENCE PAPERS 1981-82

Presented at two conferences sponsored by:

The Association of University Programs in Health Administration

The Department of Health Services Administration
The George Washington University

The Society for Hospital Planning of the American Hospital Association

David F. Bergwall, D.B.A., Editor

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Arlington, Virginia 22209

PREFACE

In August of 1981 the Association of University Programs in Health Administration jointly sponsored with the Department of Health Services Administration of The George Washington University and The Society for Hospital Planning of the American Hospital Association, a conference on Curriculum for Health Planning, Policy and Marketing. In April of 1982 this conference was followed by a session at the AUPHA Annual Meeting, again jointly sponsored, which focused on Curriculum for Strategic Planning. This volume contains the papers, responses and summary of the proceedings of these two conferences.

The rapid changes in the health planning and marketing arena in recent years resulted in these conferences. Independently the George Washington University and the Society for Hospital Planning approached AUPHA to request help in identifying ways to improve the curriculum of health administration programs in these areas. By pooling the interest and efforts, as well as the financial support of the three organizations the papers for the first conference were commissioned. The second conference was a logical follow on to some of the concerns expressed by participants attending the first.

It is hoped that the distribution of these papers will contribute to the thinking of various faculty and practitioners on these subjects. Like any such document it is limited in its ability to address such a broad topic. While the material will not be universally useful to all who read it, there may be a few challenging ideas for most.

The volume is organized into two main sections corresponding with the two conferences. The general pattern for each section is a major paper followed by responses from academics and practitioners followed by some synthesis of the discussion.

We are indebted to Professor Philip N. Reeves of The George Washington University for providing the historical context of the first conference as well as much of the energy which prompted this project. Likewise we appreciate the efforts of Professor Barbara Arrington of Saint Louis University for Chairing the second conference.

A special note of thanks goes to Carol Diggs who inherited the editing and proofing of this volume after several false starts. Likewise, thanks go to Marianne Coyne and Gwen Gulesian who typed the final manuscript.

David F. Bergwall, D.B.A.
Vice President
Association of University Programs
in Health Administration

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CONFERENCE I - AUGUST 1981

# INTRODUCTION

by Philip N. Reeves, D.B.A.

## Historical Background

The roots of this conference can be traced to a 1968 AUPHA conference on health planning. So far as we know this was the first collective effort to define from an educational perspective the scope and substance of the then emerging field of health planning. Subsequently there were other conferences on this topic, funded directly or indirectly by the federal government under Section 314c of the Public Health Services Act (PL 89-749).

As the transition from comprehensive health planning to health planning and resources development (PL 93-641) occurred the federal government sponsored additional studies concerning the training of health planners. A notable effort was the Health Resources Planning Education System developed by Educational Testing Service of Princeton, New Jersey. An important feature of most federally sponsored projects was an emphasis on preparation of individuals for the current planning system. This was a completely reasonable strategy in the light of the pressures on the federal government to develop immediately an effective, functioning planning system. On the other hand the products of these efforts were of marginal utility to the designers of academic programs, whose primary objective was to prepare students for professional careers that would clearly extend beyond the duration of any current system. This divergence of interests became evident shortly after the establishment of federally supported academic programs under Section 314c. Indeed, even before PL 89-749 was replaced by PL 93-641 (which, significantly, authorized no support for degree-related education), the federal government had effectively discontinued all funding of health planning graduate education.

Even during the period of federal support there was very little interchange among educational programs of ideas and beliefs concerning curricula in health planning. When the federal support was withdrawn, some planning programs were discontinued and those that remained tended to become even more insular. This isolationist tendency was reinforced by the fact that a major professional organization now known as the American Health Planning Association changed its membership and dues requirements in ways that virtually prohibited academic programs from participating as institutional members. Some faculty persons continued their affiliation as vote-less individual members, but it became clear that this organization would no longer serve as a focal point for interests of the academic community. Many individual faculty persons also maintained individual memberships in the Community Health Planning Section of the American Public Health Association. In fact, some have been and remain in leadership roles within that organization. Nevertheless, the Section's agenda has not addressed in any systematic way the issues of health-planner education.

A trend which began subsequent to the withdrawal of federal support for education of planners made it even more unlikely that any single professional organization could serve effectively as a focal point for the discussion of graduate educational programs. As federal support was withdrawn the scope of many surviving programs was expanded so that they became multi-disciplinary; faculty participation became dispersed among professional societies oriented toward public administration, policy science, urban planning, operations research, hospital planning, etc.

This situation persisted until 1979. In that year the Association of University Programs in Health Administration established a process to encourage and facilitate interchange among faculty with related interests. Specifically, the Association organized a luncheon session of its annual meeting in which participants were asked to form groups based upon related disciplinary/functional interests. Thus, for example, there was one group for financial management, another for operations research and yet another for marketing. Those who participated in the planning group decided that annual meetings were insufficient and consequently appointed a few people to organize additional informal sessions during the annual meetings of AHPA and APHA.

The people who attended the session during AHPA's meeting in San Francisco concluded that the most useful thing the group could do would be to sponsor a conference focused on curriculum content. The person serving as the informal leader of the group was assigned responsibility for acquiring the necessary resources and organizing the conference. Informal discussions with AUPHA revealed that they would make in-kind matching contributions of staff effort and that the out-of-pocket costs would be modest. It was next learned that the group leader's organization, the Department of Health Services Administration of The George Washington University's School of Graduate Business Administration, would provide the necessary cash from the funds it had been awarded by the federal government for program development. At about this time it was learned that another organization, the American Society for Hospital Planning, was conducting its own exploration of educational needs. When contacted, that organization quickly agreed to participate in a joint effort and to contribute additional funds so the scope of the conference could be expanded.

Plans for the conference were discussed and finalized at the informal session held during APHA's annual meeting in Detroit. A formal conference committee composed of one representative each from ASHP, AHPA and AUPHA programs was appointed. The members of the committee were: Ken Boff, ASHP, David Bergwall, AUPHA; and Philip Reeves representing AHPA programs.

The first decision of the committee was that the conference should address curriculum content from the points of view of both academicians and practitioners. It was also decided that the conference would be descriptive and exploratory. In particular, no attempt would be made to define or prescribe an ideal curriculum. Next, on the basis of multiple inputs (an ACEHSA study on policy and planning, the emergence of new journals, comments of participants in the informal session and the ASHP study), it was decided that the conference ought to consider different conceptions of planning and to examine the possibility of integrating them within a curriculum. The conceptions chosen were community health planning, institutional health

planning, policy-making as planning, and marketing as planning. The remaining decisions of the Committee dealt with format and participation. A survey of academic institutions indicated widespread interest in the conference; it was therefore decided to offer registration on a broad basis rather than to limit participation to a small number of selected invitees. The format was designed to meet two objectives: to assure imput from both academicians and practitioners, and to provide ample opportunity for all registrants to participate in the proceedings.

# A CURRICULUM IN COMMUNITY HEALTH PLANNING: AN APPROACH FOR TODAY AND FOR THE FUTURE *

by Henrik L. Blum, M.D., M.P.H. and
Christopher Bellavita, Ph.D.

## PART A: AN APPROACH TO DETERMINING WHAT COMMUNITY HEALTH PLANNERS OR POLICY ANALYSTS NEED TO LEARN

The task of outlining a suitable curriculum for health planning or policy analysis must be built upon an understanding of what it is that health planning is to accomplish. We will look at this task in two ways.

### I. A Normative View of What Planning Involves

Beyond question, the overriding purpose of planning is to obtain social change. Planners are put to work with only one consideration in view, to ensure that tomorrow will be different than we forsee it will otherwise be if today's currents are allowed to continue. Even if planners are asked to retard or reverse current trends so that tomorrow will be kept like today or yesterday, we are talking about producing a change. Maintaining status quo in the face of impending change is an act of social change, because if the planner is asked to maintain the status quo in one area, he or she obviously must introduce changes into the lives and activities of other areas or sectors if the planner's mission is to be accomplished. The social changes needed to turn back the rising tide of crime or drug abuse, for example, hardly involve the justice or health sectors, but call for massive economic and social relationships readjustments.

The planner in the public agency had better recognize the enormity of the planner's role as social change agent, the effort involved in bringing about desired changes, the inevitable widespread distrust of such planner-inspired changes, and the inevitable enemies who will fight every step of the way because they regard the present or the anticipated future as highly advantageous. As we shall see, many planners will also be employed to fight publicly-planned change, and planners on either side of such change-based controversies would do well to understand the interests and values that fuel the controversy. Above all, they had better understand what society has at stake in their proposals and counterproposals, so that some democratic accommodations can be made without risking freedom-destroying control, future-destroying blind harvest of scarce resources, or revolution-building maldistributions.

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*Some of this material is drawn from a more elaborate discussion in
1) H.L. Blum, Planning for Health, 2nd Edition (New York: Human Sciences Press, 1981).
2) H.L. Blum, "Health Planning Methods: An International Perspective," U.S.D.H.E.W., PHS, HRA, DHEW (HRA) No. 79-1402, September 1979.

Planners therefore must be adept at sizing up the ever-changing hierarchy of values--the ideologies and interests at work--and be aware of the resulting dissonances among various actors when these fall out of line with one another. Planners must learn techniques to aid their perceptivity of the forces they deal with and to estimate not only their direction but their intensity, as well as what can motivate and obtain compromise or even redirection.

This normative view of why planners are created and utilized tells us that they must understand human behavior as it moves individuals, small groups, larger groups or communities, and societies or nations. It tells us that planners must be able to create impetus for the changes they propose. They must be able to identify the structural controls that stand in the way and design effective approaches for sweeping them away. Planners must likewise be able to identify the internalized (even if unacknowledged) internal controls that inhibit various changes in all individuals, and planners must provide the vehicles for liberation from these inhibitions. Finally, planners have to design and prepare the mobilization required to harness the impetus and overcome the structural and individually internalized roadblocks to the proposed changes.

What emerges is a requirement for a suitable grounding in social psychology, political science, economics, and ethics. We add ethics, having perceived the enormity of the responsibility involved in introducing social changes which may advertently or inadvertently disadvantage many. To the comprehension of what produces social change and how to achieve certain desired changes must be added a comprehension of the nature of health, its manifestations, how to improve it and how to measure it.

## II. A Problem-Solving View of What Planning Involves

The authors have become wedded to the idea that offering guidance on any area of human endeavor involves more than normative prescriptions. It must also involve reasonable analysis of the issue under consideration. Thus we now offer an analysis of the concern which surely underlay the request that we "outline an adequate curriculum in community health planning." That concern is ineffective health planning in the United States.

A crude analysis of ineffective health planning is laid out in Figure A-1. It reveals many sets of forces and impacts, each of which in turn needs analysis or consideration. Our analysis reveals many reasons for failure of health planning, of which, on the face of it, we have only been asked to address one, "bad planner education."

If planning is to be effective, however, and if planners are to have a key role in that implied turnaround, the planner's education must of necessity encompass understanding of all major sources of health planning failure and provide planners necessary insight and willingness to attack these sources of failure. The planning education must also help planning students who cannot tolerate the inevitable wedding of technology and politics to weed themselves out, or go into very specialized planning areas that do not partake very heavily of the rich political ecology involved in effective health planning.

We conclude from the view of the reasons that planning is so ineffective

Figure A-1*

Analysis of the Problem
"Non-Effective Health Planning in the United States"

| Precursors | | | | | The Problem | Consequences | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| anti govt. Individualism help the underdog rapidly growing economic unravelment with its concomitant social, political, and individual unravellment, fractionated politics, simplistic "safe cures" from the past, complex "unfamiliar cures" from the future | Diverse and conflicting USA national perceptions of planning<br>1)exchange of info<br>2)participation and lean to understand one another<br>3)logic put to work<br>4)moral suasion<br>5)don't threaten individual interests<br>6)preserve the market<br>7)regulate as needed<br>8)cost-benefit measures<br>9)serve public purposes<br><br>Theoretical, less diverse, but still conflicing views of planning<br>1)deliberately intended social change-logic<br>2)built on publicly reconciling unduly divergent ends<br>3)utilizing and choosing among appropriately weighed alternatives interventions<br>4)great concern for secondary effects<br>5)great concern overall utility on a wide set of criteria not not just $, i.e., public purposes<br>6)control<br>7)problem solving<br>8)building futures | -poor and diverse comprehension of planning possibilities<br>-ambivalence about public planning<br>-success of private planning until recently<br>-medical care confused with health<br>-use of, and who can get what out of govt.<br>-competing rather than integrating goals of cost, health, equity, quality | -bad planning education<br>-diversity of powerful vested interests goals<br>-no meaningful consumer voice<br>-prestige of those in medical care<br>-size of financial entitles involved in health care<br>-control of competition, practice<br>-segregated care or financing for the poor aged<br>-support of specialist education<br>-suppression<br>-bad planning laws | -incompetent planners<br>-premature planner specialization<br>-irrelevant planning structures and relationships<br>-no one designated to receive or act on planning output<br>-irrelevant imposed planning purposes and guidlines<br>-irrelevant imposed planning processes and tools<br>-domination of cost control as govt. taxes support more of care and industry foots larger bills as a painful pass-thru | Non-Effective Health Planning in the USA | divisive<br>no action<br>misleading emphasis on care, not health<br>misleading emphasis on health sector, not on sectors affecting health<br>misleading emphasis on cost, not distribution or effectivity<br>misleading emphasis on regulation, not on gaps | discredit all planning<br>focus on short term irrelevencies<br>as unused beds, but not on finance or organization of delivery | raise costs<br>sock in what we have, | -promote use of market for wrong purposes e.g., "consumer choice" re costs<br>-ignore use of market for right purposes as alternative price competing sources of care<br>-do away with all regulation not asked for by providers<br>-excessive costs for all means, excessive cost to govt. for care of poor | -no meaningfull regulation<br>-no market possible without meaningful regulation<br>-govt. cuts eligibility and scope of coverage for the poor segment of society with most and worst problems and and least resources | -promotion of further political economic socio-cultural unravellment<br>-increased illness and more costs |



*PIA (Problem and Issue Analysis)

to date (Figure A-1) that the adequate planner must not only learn the planning tools to use and when their use is suitable (a disaster area now), but must seek to create suitable planning structures; necessary technical, administrative and political relationships; and a general planning framework in which planning can take place. Presently the planner typically accepts these elements of the planning infrastructure as he or she finds they, even when they preclude planning and thus the achievement of significant desired social change (the only reason the planner has for undertaking planning).

Above all, the planner must understand the meaning of his or her assignment in society, and the forces to be contended with. These forces may vary from issue to issue as well as over time, e.g., from election to election. The planner must penetrate the nature of their beliefs and interests and the sources of their power. The planner also has to comprehend the planning and organizational niche he or she occupies, its functional restraints and opportunities. The planner also has to understand the role and policy arenas of other planners who work above, below or laterally in fields which impact on his or her work in health, whether it be finance, environment, employment, or whatever. In spite of what seems to be a mounting thicket of constraints and special interests to be taken into account, it is comprehending their existence and possible relationships that gives the planner enough of a grasp of reality to effectively introduce change.

We must, at this point, emphasize the need for planners to do a substantive problem-or-issue analysis (PIA) as we did with our issue of "planning failure" in Figure A-1 before they rush on to an analysis of political constraints surrounding a given issue. If they do the political constraints first, they typically so limit their vision of what is presumed to be possible that no basic substantive understanding of an issue will occur (i.e., certain forces such as gravity, the mode of spread of a disease, the impossibility of getting care to the poor without appropriate resources, etc., are at the heart of a matter and must be planned for first). Conversely, by starting with the systems-type PIA approach (see Figure A-1) we do learn what leads to what and where one can substantively intervene.

After choosing the probably more feasible and effective interventions, the planner can then determine in which policy-making arena each specific intervention must be acted on, who the actors are likely to be, and how involved they will get (Figure A-2). At this point the planner may remove some otherwise good substantive options because they are politically hopeless, find ways to make others acceptable to currently powerful opponents, or set the stage for efforts to overcome political opposition to those options he or she regards as highly effective and essential.

A classic example of succumbing to power blocs first, and failing to come up with a useful intervention for lack of a substantive PIA-type analysis, was our major American effort to overcome low availability of M.D.s to various population groups, most pronounced in a dozen rural states. The apparent absence of any organized PIA led to an obviously stupid answer (as Churchman says, "environmental fallacy"): "the United States must train more M.D.s." Bowing in advance to medical political pressures that federal money should not dictate training needs or curriculum, but could be pumped into research, we soon had a growing output of M.D.s, but primarily of subspecialists, researchers and teachers. The dozen deprived states continued in their

deprivation because the new trainees were all the wrong kind, i.e., they needed a large population base and heavy support from all other specialists--just what the states with low-density, underserved populations could not offer.

## III. Our Approach to Curriculum Content

By combining our two sets of insights, derived from our normative view of what planning is all about and from our problem-solving view of why health planning has been so ineffectual, we feel that we can offer a reasonably defensible set of recommendations for training health planners. This approach leads us to emphasize a variety of "slices" or views that one might take in considering what planners need to know and do. We did not find it advantageous to examine planning education from the standpoint of the disciplines that have something to offer; rather we found from our problem analysis that what planners most need to know is how to move among the environments and demands that determine their work and survival. Since those "real life" issues rarely occur in disciplinary categories, we have categorized the "real life" planning situations in what we think are the important work distinctions. Having done that, we then looked to see which of the various disciplines would contribute significantly to an understanding of the matters at stake in the given work category.

We emphasize the illumination that consideration of each setting in which planning is done sheds on the overall capacities required of planners. For example, where on the social change stream (Figure B-1) the planner is working sheds light on the whole sequence and how he or she must relate to those planning and working elsewhere on that chain of events. The planner must be equally at home with the diversity of tasks faced by planners who specialize in different elements of the planning process (Figure B-2), no matter at what place on the social change stream they do their planning. Even though any one planner might be limited to dealing with a small area of any of the elements of the planning process, we believe the planner could not be expected to do very well in that area without at least a general comprehension of the rest of the planning process, which we think we have reasonably portrayed in Figure B-2 in spite of our reductionist approach.

We follow the views revealed by our "slices" through planning by a composite view of what the health planner needs in the way of capacities and the courses and experiences needed to procure those capacities both before, during, and after the M.P.H. experience. We conclude with a long-term strategy for the planners' education beyond the M.P.H., which we think will be their most critical challenge in the fast-paced changes of uncertain direction that we all--and planners especially--face. This enduring educational strategy will have to begin during the M.P.H. if the schools which train planners are doing what is relevant for the planners' training, and we suggest how that long path might be begun in training centers.

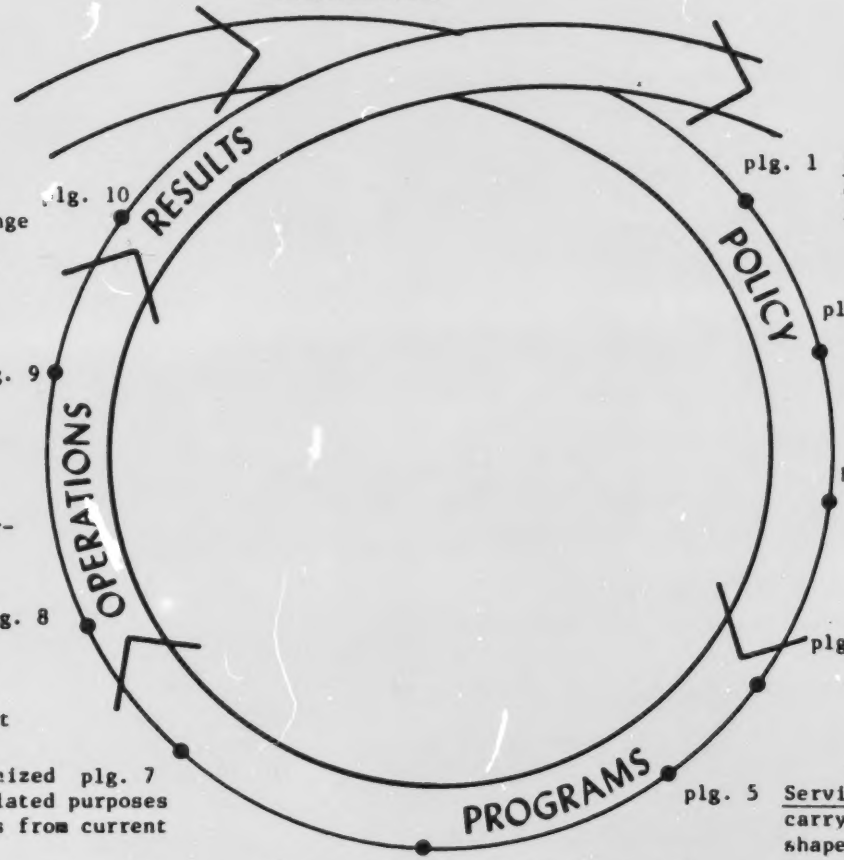
We wish to make several caveats at this point.

1. As we speak of what 'the planners' must know and do, we do not envision the planner as an independent actor who determines what is wanted, what is a 'good' plan, or even what is the best way of proceeding. We see the planner as the reservoir of understanding: the one who can help clients prepare an

# FIGURE B-1

## STAGES OF THE PUBLICLY PLANNED SOCIAL CHANGE SEQUENCE*

4-1-79
Adapted from
H.L.Blum
"Does Health
Planning Work
Anywhere?"
American Journal
of Health
Planning,(July,
1978) 3:3, 34-47




plg. 1 Philosophy, developed from implicit or explicit value-belief systems and applied to the concern at hand

plg. 2 Policy, formulated from philosophy (particularly the social-economic-political forces) as applied to the concern at hand

plg. 3 Legislation, formulated to carry out policy purposes (as shaped by personal and special interest concerns of legislators)

plg. 4 Administration, organized so as to carry out or oversee legislated purposes (as shaped by organizational and individual bureaucratic pressures)

plg. 5 Service Systems, organized so as to carry out legislated purposes (as shaped by pressures from established interests)

plg. 6 Service Agencies, organized so as to carry out legislated purposes (as shaped by pressures from currently viable units)

Service Programs, organized plg. 7 so as to achieve legislated purposes (as shaped by pressures from current providers)

Service Delivery Units, organized so as plg. 8 to carry out legislated purposes (as shaped by pressures from current providers-users)

Provider-Server plg. 9 Relationships, built around personal role expectations and interactions called for by legislative mandate (as shaped by current provider-user pressures)

Outcomes and impacts of plg. 10 the legislated social change

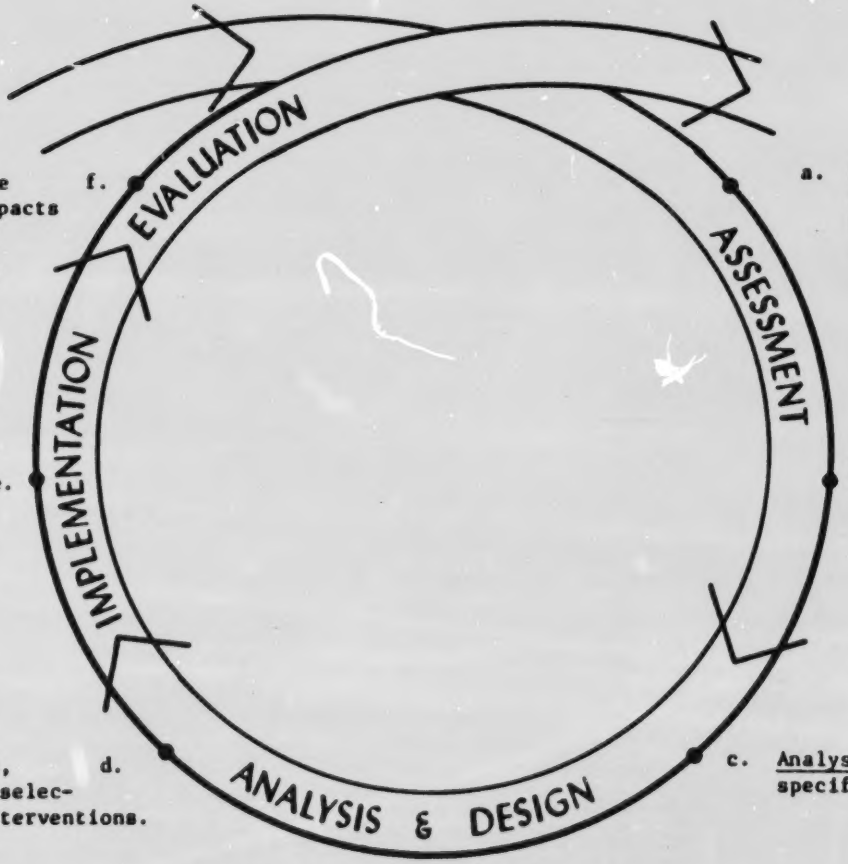
* entire social change cycle and its stages shaped by the environmental force-field of cultures, traditions, values, beliefs, socio-economic-political ideologies, intra-national conflicts, political parties, governance, international pressures, and by the interests of those most involved at each stage.

# FIGURE B-2

## ELEMENTS OF THE HEALTH PLANNING PROCESS*

3-1-79

Adapted from H.L. Blum, "Does Planning Work Anywhere?" American Journal of Health Planning, (July, 1978) 3:3, 34-47




a. Measurement, determination of where we are, where we are likely to be, how we feel about it, and what we want.

b. Interpretation of data, identification and selection of wants (problems or goals) and grand ideologic GOALS.

c. Analysis, understanding nature of specific wants.

d. Creating the plan, design, analysis, comparison and selection among alternative interventions.

e. Implementation, obtaining policy commitment to the bureaucratic action on the plan.

f. Evaluation, analyzing the outputs, outcomes and impacts occurring as a result of planning.

* entire process and its elements guided by the prevalent socio-economic political outlooks, relevant legislated policies, political environment, resources, governmental structure and planning expertise.

appropriate agenda, make clear what steps are necessary, what means are available, how to organize an analysis or evaluation, phrase a goal, meet the public, influence interests and policy-makers, and so on. The planner, however, is not the all-knowing decision-maker, not the direction-setter or finalizer; the planner is the guide--the source of advice, suggestions, know-how, on occasion of inspiration for new insights and new ways for which the planner has no right to expect adoption unless he or she can help create or supply the necessary skills of influence.

2. When we speak of the M.P.H. we mean to include any of the professional planning or policy-analyst degrees which produce graduates willing to work on planning or policy aspects of health issues. The M.P.H.s provided by schools of public health and health planning are no more adequate models of what is needed than are the other masters degrees from the grand variety of schools which provide them. We observe the curricula and texts they use and, more to the point, we see the handiwork of their graduates, much as does Howell Baum: a grand collection of skills sadly misplaced and misapplied in the environment in which the planner lives. Schools such as those of urban and regional planning, public affairs, public policy, policy analysis, public administration, business administration, hospital administration, and public health all tend to emphasize one or another set of skills without setting their area of emphases suitably in focus on the stage in which their graduates must practice.

Since any categorization of deficiencies by class of school seems irrelevant to the issue of what the field calls for, we will ask the reader to regard all of the masters degrees in the field as potentially deficient in one way or another when compared to what is called for. Given the institution and degree with which one is concerned, one can be guided by the overall considerations as well as the specifics which eventuate in this treatise. It is against these suggestions that faculty or potential students can compare any particular degree offering for adequacy in one or another way.

3. As we proceed into the demands that a curriculum in community health planning must meet, we do not imply that there should or need be an autonomous health planning curriculum. If there is such a program, however, we believe that it should be guided by our observations. If health planners or policy analysts are taught under other policy or administrative rubrics we still think that they need to learn what we have prescribed. The fact that would-be administrators, analysts and others also need a very similar set of skills does not affect our perceptions of what a would-be health planner or policy analyst must be able to deal with.

4. Health planning, whether in behalf of the community, a government, an institution, or a given health service, involves the same general understandings even though each type specializes at a different point on the social change stream (Figure B-1). Thus we will talk in terms of a curriculum in health planning, rather than one of community health planning, from here on.

## PART B: THE SCOPE OF HEALTH PLANNING

If the dominant purpose of health planning is to obtain desired social changes which will improve health, there must be a minimum set of

understandings that every health planner possesses. We will pursue each of the major areas of concern in this undertaking that our earlier slices have revealed.

Perhaps the first and most basic as well as most limited set of understandings are how to utilize and carry out the demands of the planning process (PP), which we designate as assessment, analysis-design, implementation and evaluation (Figure B-2). Even more critical is the planner's comprehension of where on the social change stream (SCS) he or she is located and by virtue of this placement what is most needed (Figure B-1). Many health planners and planning bodies seem to do little more than try to survive among the institutions and structures that relate to the planner's place on the SCS and therefore determine how the elements of the PP are to be applied where the health planners are functioning. Once the planners are alert to their place on the SCS and how the planning process works at that niche, they must take into account the realities of how their society works, what it believes in, its resources and its governmental structures. Six omnipresent determinants will be explored which effectively determine which processes and which pathways can or must be utilized.

If these are an outline of the realities of getting desired social changes, the planner must undertake certain behaviors in order to produce and get meaningful plans implemented. These we shall call roles. Presently it is our observation that few indeed of the planning bodies exercise judicious choice of roles available to them (or are even aware of those they have assumed). They are equally oblivious of the implications each role carries for them, and of the required planning resources and activities that are called for if various roles are seriously undertaken. In turn, we consider the size of the systems to be examined in attacking a given issue, the source of the planner's employment, to whose interests the planner gives priority, the design and location of planning structures and organizations as they fulfill needed contacts and relationships, and the relationships of planning in different subject matter areas.

## I. The Elements of the Planning Process

Nearly every country and planner claims to be using a cyclical planning model (whether it be for problem-solving or goal attainment) conceptually similar to that shown in Figure B-2. The PP begins with an assessment element, (a), which describes where we are, what we want in the long haul (major purposes or ends), and what we want now (such as specific problems to be solved and specific goals to be reached). It also attempts to anticipate where we are likely to be and what we will want at various future times under current and anticipated influences and activities. The PP continues with another element of assessment, (b), devoted to interpreting the data and selection of what stands out as specific desired futures (goals) and of certain problems which seem to deserve priority for remedial action.

The next element, (c), is a systems-type analysis of the selected goals or problems which will point out where and how we can hope to intervene to attain high-priority desired goals or get rid of high-priority problems. The following PP element, (d), converts the analysis of the preceding step into tangible, specific alternative proposals for intervention. This includes an analysis of what each proposed intervention is likely to accomplish, with what

costs and what side effects, as well as analyzing the barriers to attainment. This step concludes with a comparison among the possible interventions, and selectively packages into one plan those most likely to make up an acceptable, successful and efficient approach to what is desired. The following PP element, (e), is that of obtaining implementation of whatever the "plan" calls for. This is a complex issue which will be examined in several contexts. The final PP element, (f), calls for evaluation of what the planning did or did not produce. Evaluation also informs planners and others about failures in their knowledge of the condition being attacked, as well as of their incapacities to correctly gauge how to achieve successful implementation.

It is well to remember that:

- The planning process elements do not take place in an immutable order;
- The basic planning process remains the same at every stage of the social change stream, but how its elements are carried out does vary with the stage of the SCS.

## II. The Social Change Stream

Health planners and policy analysts have for too long overlooked one or another aspect of the deliberate social change stream (Figure B-1) which is their specific charge. In some countries they have pretty much left the policy stages to anyone or no one; in others they seem to have forgotten the programmatic or operational requirements. In still others planners have each gone their own way with the piece they believe assigned to them, as though each of the stages could live independently and somehow--by only their own efforts--turn the available resources into the desired ends. In few countries were the planners explicitly given (nor did they take) the major task of designing social change so that prevailing philosophies, goals, and problem solutions were turned into policy which allocated resources that were really converted into what was envisioned.

Figure B-1 is presented as a conceptual planning framework for achieving deliberate social change. It can be conceived of as having as many as ten relatively distinct stages, and is best visualized as a cyclic process. For ease of discussion, each stage is given a number and the planning process that creates it is given the same number. Planning 1 is that application of the planning process which is dedicated to organize and in some cases invent a philosophy out of relevant belief and value systems. It will guide a society's efforts in behalf of health and health care. Planning 2 takes the philosophy and boils it down to a policy capable of directing resources and energies. Planning 3 takes the policy and converts it into legislation. Planning 4 creates the administrative machinery. Planning 5 designs the relevant service-system organizations so as to do the job in accordance with the legislation. Planning 6 designs the organization of the relevant service agencies so that they can function suitably as sub-systems of the designated service systems set up in Stage 5. Planning 7 designs the programs which are the function entities carrying out the designated assignments of the service agencies. Planning 8 designs the service modalities at the actual point of application. Planning 9 designs the server-served relationships and setting so as to carry out the legislated purposes. Planning 10 designs the descriptions or criteria of the effects, outcomes and impacts which are to be

weighed and measured. These are required to tell planners, policy-makers, implementors, and the citizenry at large what ultimately is to occur from the intended change. Describing the SCS in fewer but more inclusive terms shows it to consist of four areas: policy, programs, operations, and results.

- The SCS figure does not imply that every publicly-intended social change takes each stage of the route described.
- Planning for the stages does not occur in an immutable order.
- Not all stages of a SCSs are done at the same level of a society. It needs to be pointed out that there are major differences among countries as to which levels of community or government carry out the planning for which stages of a SCS.
- There are many related SCSs. A given national issue such as national health insurance represents one national SCS. A strategy for improving health could be another SCS. They need to be related and handled consistently, i.e., to share basic philosophies and policies.
- The same change-producing activities described in the SCS go on in non-governmental quarters, but typically for different goals.

## III. Societal Determinants of the Acceptance of Planning, and of the Nature of Planning Structures, Participants, Processes and Agendas (Planning Environment)

In every country there are at least six major sets of forces at work which among them dictate in both obvious and subtle ways how much planning will be utilized, how well it will be supported, what approaches can be taken, what tools will be utilized, what can be planned for, and who can participate. These forces can be examined individually, but it is the complex thrust of their intertwined reactions that determines how health is to be planned for in a given country (Milio). Planning institutions and organizations do not spring up in a social vacuum.

### A. The Dominant Social-Economic-Political Ideology

The dominant social-economic-political (SEP) ideology pretty well determines a country's posture on (1) the desirability of undertaking deliberate social change, i.e., the use of planning in and for the public sphere; and (2) if desirable, by what kinds of interests and by what kinds of planning approaches. The spectrum of SEP ideologies runs from a perception that public government exists specifically to plan for and obtain whatever it thinks is good for its people, to a belief that absolutely no governmental action is justified other than to maintain an environment in which private enterprise can plan, organize, and produce whatever and however it wishes.

The middle ground is a more interesting one for us in the United States. It stems from SEP ideologies which accept the role of government as being actively involved in behalf of the welfare of all its citizens. But these ideologies do not agree on the extent to which private pluralistic forces make the decisions for and in government.

Alford makes the point about the U.S.A.:

> An explanation of the deep-rooted character of the dynamics without change must thus... go back to the dominance of the private sector and the upper middle class...Thus, a major characteristic of the public sector is that it does not have the power to challenge the domination of the private sector...Government policy is not fundamentally important except insofar as the policy is not to interfere with the private sector, or only to come forth with financial subsidies for the private sector.

## B. How Government Is Organized and Where the Various Stages of the Social Change Sequence are Assigned (See Figure B-3)

Organization of any government is of course also the outgrowth in part of the prevailing SEP ideology, cultures, traditions, external pressures, availability of resources, and so on. Once established it has direct effects on how a social change sequence is undertaken and to what levels its various stages are assigned for planning and execution.

### 1. Levels of Government (or Non-Government) Involvement)

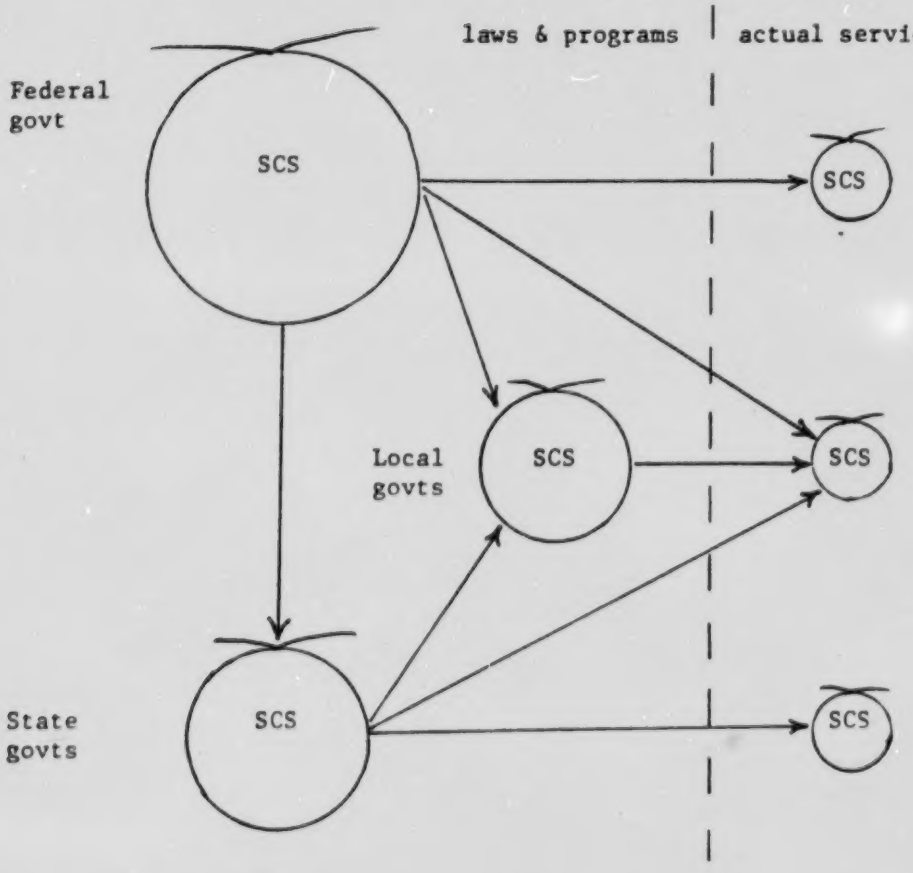
When we examine where planning is done for the various stages of the SCS, we find tremendous variability. For a national level SCS in the United States, planning for Stages 1, 2, 3, and some of 4 are usually done federally, with some guidelines laid down for the lower levels which are to do the planning for much of Stage 4 and nearly all of Stage 5 through 10. (The level at which the handoff occurs varies with the issue or SCS at hand).

Even though lower levels take over planning and/or operations for Stages 4 through 9 of a nationally-initiated SCS in the United States, they too must begin by planning their own policy Stages 1, 2, and 3. This may seem to be a small matter; but in fact, if the Stages of the national SCS assigned to a state are of any consequence, doing their own Stage 1, 2, and 3 may be the states' major initial task (usually called organizing) before they can proceed with planning for the remaining Stages of the national SCS which were assigned to them. (See Figure B-3.) In turn, a more local-level assignment, as for a city or county, receives guidelines from the state and national SCSs. While incorporating them, it creates its own policy Stages to be used as the framework from which it plans for the Stages of the national SCS which it has been assigned.

It is not hard to see that if all planning chores for Stages 1-6 (Figure B-1) are kept at the national level, there could be a great deal of consistency as to how and what is to be done, e.g., Medicare in the United States. If Stages 4, 5, and 6 (as well as 7 and 8) are to go to the intermediate, or to more local or private entities, as is the case for Certificate-of-Need (CON) and Medicaid in the United States, it is evident that any leeway left for such agencies to construct their own Stages 1 through 4 is likely to result in significant variability.

Fifteen years after the program's enactment, one intermediate-level jurisdiction—Arizona--has no Medicaid program (care for the poor). It can also be said that no two states have quite the same philosophy about what

Figure B-3, Passing on the Social Change baton from one level to another to the health care "system," of services




federal health service entities, e.g.
- HHS + PHS
- VA
- Armed forces
- etc.

the majority of health care providers, e.g.
- private practitioners,
- not-for-profit institutions
- proprietaries
- local govt. services
- etc.

state health service entities, e.g.,
- state hosp's
- Medicaid
- etc.

national laws on planning, CON or Medicaid are to accomplish. Increasing the confusion is the fact that health planning for Stages 4 through 10 is done independently in a given community by non-governmental profit and non-profit entities, as well as by all levels of government (often as many as four) that produce services for the community. (See Figure B-3.)

Canada, by contrast, does a heavy job of Planning 1 and 2 and a bit of Planning 3 at the national level. By the nature of its "constitution" it turns over nearly all of Planning 3 and all of Planning 4 and 5 to its provinces, many of which also do the bulk of 6 through 10, while others often turn over the major portions of Planning 6 through 10 to local governments and non-governmental entities. As in the United States, each province (state) has to plan its own Stages 1 and 2 in order to follow through on a national SCS.

The same kinds of issues arise among the various levels of non-governmental organizations depending on their degree of autonomy and central relationships.

2. Separation of Planning from Administration

In cases where government at any one level is doing both the planning and the production of services, it is often the case that the agency doing the major planning is quite unrelated to the one doing the producing. This is quite a different issue than the one of whether the planners are the same persons as the administrators in a given health ministry or agency.

3. Significant Involvement of Non-Governmental Entities

In the United States much of federal health care Planning 4 and 5 and most of Planning 6 through 10 is done by delivery entities, the bulk of which are non-governmental. Some are non-profit, some are run for profit. At the same time, and totally without coordination, the nation, the states and cities and counties also have service delivery units for which they are fully and directly responsible and for which they do Planning 1-10 (See Figure B-3).

The basic planning process (Figure B-2), the elements of which are so extensively adapted to fit the circumstances, remains the same for private as for public, and for profit as for non-profit entities. What is different are the ideologies and purposes which guide the participants who are formalizing them into goals and then into plans.

4. The Number of "Transfer" Points for Stages of the SCS

The number of "transfer" points for carrying out stages of a SCS where many levels or agencies participate, as between nation, province, local and private entities, probably correlates fairly directly with the ability to veto, delay, countermand and prevent deliberately-planned social changes.

5. Overlapping Spheres of Concern Among Various SCS

Planning to overcome breaks in intended responsibilities and to maintain continuity of purpose between levels doing parts of a SCS are further complicated by the effects of overlapping spheres of concern. For example, at the national level the planning and administering of alcohol and mental health

programs may be part of overall health concerns at a Department of Health. At the intermediary level, alcohol may go to a law enforcement entity for planning and mental health to a welfare entity; at the local level, all may be recombined or further disintegrated into numerous public and private entities. Thus does complex bureaucracy frustrate providers and consumers alike.

### C. The Dominant Ideologies about the Nature of Health and How Health Care Relates to Health

#### 1. Use of the Force-Field of Risk Factors Paradigm (Figure B-4)

At the national level in Canada the "force-field of risk factors" is now the dominant paradigm (Lalonde, Pawles). A first planning step is a combined assessing-analyzing one which searches for the major categories of premature mortality or morbidity and then for the prime forces which causally underly them. This also involves a stance which contrasts a possible future with the present. Here a problem is not what we recognize as something that is out of line now, but something that would be out of line if the future were rid of a certain risk factor. The unconcern for this ecologic paradigm and the use of the "medical care equals health" model in so many countries is manifested by their lack of investment in overcoming or even exploring the underlying causes of ill health.

#### 2. Use of the Well-Being Paradigm of the Inseparability and Transmutability of Psychic, Social and Somatic Health

This ecologic paradigm represented by the center of Figure B-4 suggests that all human support services should be integrated at the point of primary care, an entry point for those with hurts or problems of any sort. Manifestations in one sphere may be caused by stresses in others (even most "accidents" are not accidental).

### D. The Stage of Development

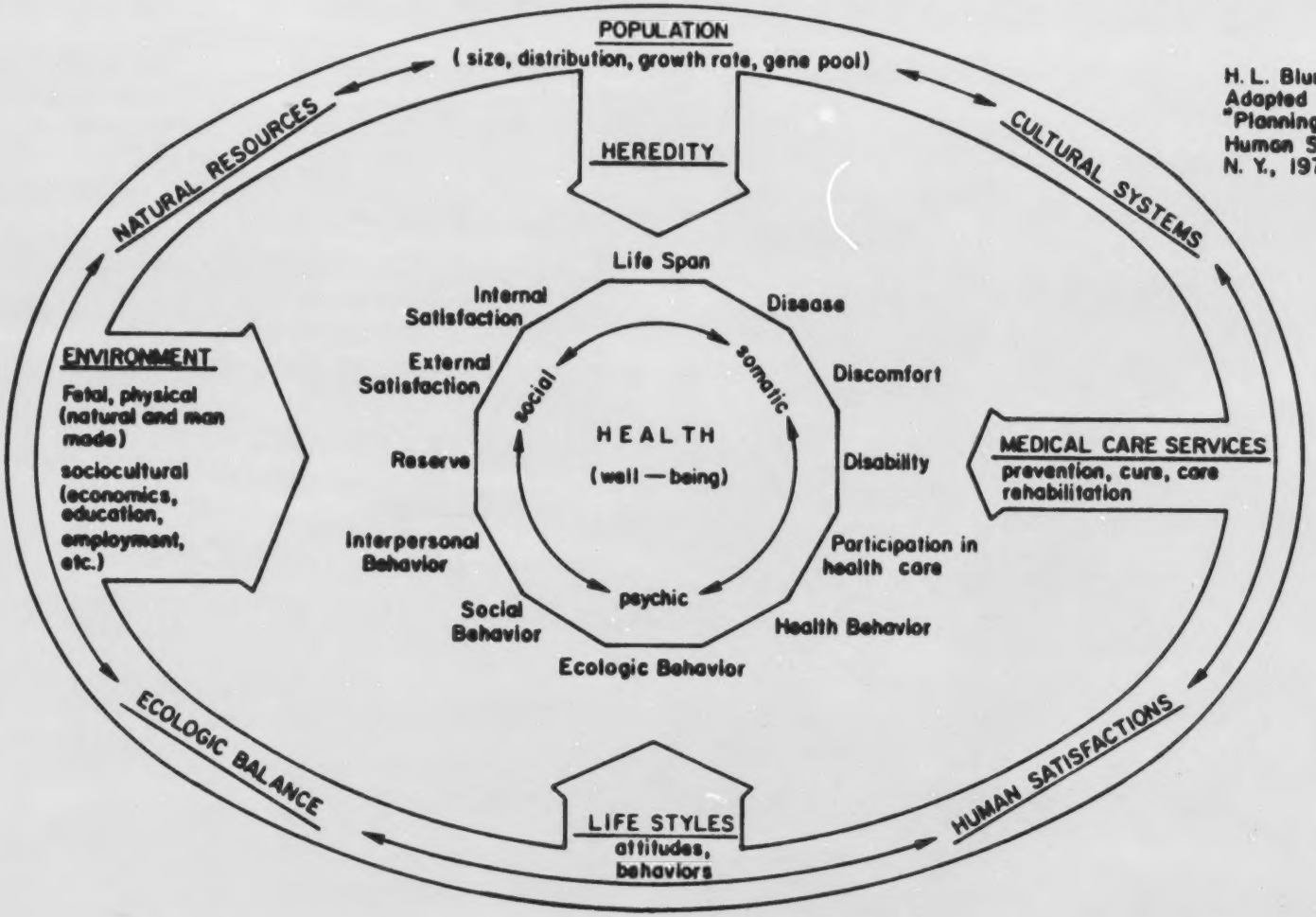
One of the major factors in determinig the nature of all aspects of health planning is the stage of a country's development. In general, a serious lack of skilled manpower is usually paralleled by a lack of purchasing power and unavailability of resources. In recent times a handful of less-developed countries have been able to exploit their natural resources to the point of being wealthy or at least reasonably well-off, but they still suffer from a lack of skilled manpower and often import this manpower from quite foreign cultures.

### E. External Pressures and Supports Which are Related to Promotion of Foreign SEP and/or Health Ideologies, Planning Approaches, and Methods

Many, if not most, less-developed countries (as well as many developed ones) are heavily constrained by the immediate presence of powerful helping or pressuring neighbors. They are often forced to adopt planning means to suit or outwit those whose aid or hostility constrains them. A country that has the misfortune to receive gifts from several sources, each with a different planning stipulation, can be hamstrung.

FIGURE B-4

## THE FORCE-FIELD AND WELL-BEING PARADIGMS OF HEALTH




H. L. Blum, 9/1/78
Adapted from H. L. Blum, "Planning for Health", Human Sciences Press, N. Y., 1974.

A not too dissimilar phenomenon takes place inside a given country at lower levels of government, when largesse from higher levels comes for isolated and multiple stipulated categories of needs, groups, places, services and so on. Local resource allocations (here usually called budgeting) may be totally gerrymandered and local planning and programming sent topsy-turvy by attempts to make use of outside moneys (which are not even promised continuously) in attempts to augment services or local tax levies.

F. Cultures, Traditions and Current Practices

One of the major elements of the planning process is designing alternative interventions (innovating) once a problem or goal analysis has revealed suitable points at which the system can be leveraged into doing what is desired. Unfortunately, what people have never seen before does not easily occur to them. This is combined with a logical tendency to use or use up what is on hand. Innovation is not easily created or accepted.

It is worth noting that the characteristics of any one of the six determinants is not necessarily a very good indicator of how any of the others will work. For example, the SEP ideology does not really parallel the health-health care ideologies. Four so-called Marxist societies—China, Cuba, Yugoslavia, and Russia--have significantly different views and practices about health. Yet all claim to subscribe to a Marxist socio-economic view of the origins of good and bad health.

Among the Western, industrialized, low-mortality, non-Communist societies, only Canada is really involved with the force-fields and the combined human support services. More collectivistic or welfare-oriented developed countries such as Sweden, Norway, Denmark, England, the Netherlands, etc., all have a high health status but none compare themselves with what could be (Canada's goal orientation of better health).

G. What Use Planner?

It seems appropriate to ask, "Do we need planners or social change agents if they must abide by conventional SEP wisdoms, be limited by outmoded governmental and political structures, respond to external and even extra-national pressures, be constrained by powerfully projected but irrelevant concepts of health, and so on?"

As usual, the either-or has been put too precisely. What can and must be done to justify the activity of planning is to build a consciousness of all those interests, wisdoms, beliefs and values that are significantly at work. This is done by energizing the active participation of the relevant diversity of view-holders who thus help educate one another. From this challenging confrontation new understandings and tolerances of perceptions and interests of other can be spread to the general populace as well as the policy-makers.

It is hoped that the planner can be taught how to anticipate the relevant diversity, taught how to put the contestants together profitably, and taught how to draw higher levels of cogency and means of change out of the diversity. Finally, planners must be taught how to use the planning participants as the means of educating and persuading the public and its selected policy-makers to utilize the proposed new plans for social change to which they have contributed.

Perhaps the key role of planners can be summed up by saying that they must be taught to operate within the range of their society's conventional wisdom, but take advantage of its anxiety over its unsolved problems. They can gather all concerned over these problems and point out the multiple conventional wisdoms, their inconsistencies and incompatibilities with one another and with reality. This gives planners the opportunity to point out the emerging understanding and new possibilities.

Their work extends to an ability to recognize when they have too vigorously bumped into beliefs, values, and interests that have not come abreast of the current realities. They must be able to decide when to do what can be done with reasonable ease; when to turn back because of danger of achieving a gain which can in fact become a permanent roadblock to long-run ends; when to move as much as possible because it sets the stage or platform from which the future efforts can be mounted to desired larger ends; and when to embrace conflict as the best means of creating awareness of the real issues. Above all, planners must know when to fold their tent and leave a field that has become unresolvable and an endless drain on limited resources.

The planner must understand the paradox that the planning machinery is likely to be created by a society in just the way that it creates its problems. Thus, its planning machinery is not able to deal with the issues straightforwardly. This comprehension usually frees planners to go a few steps further than their society's guidelines for planning would seem to indicate. By referring to the officially-stated purposes of the planning policy as provided in legislation, the planner can usually find a mandate to go well beyond subsequent bureaucratic tampering (Stage 4 in the SCS, Figure B-1) which often results in constraining rules and regulations or guidelines. Although these constraints are, by implication, related to those purposes, they are in fact often irrelevant and antithetical to those purposes and often to planning itself.

## IV. Choice of Roles to be Undertaken

We have already referred to the need for knowingly taking on certain behaviors that correspond to what the planning body believes it should and can be doing. Without this awareness of the nature of the planning skills to be acquired, the allocation of resources becomes haphazard and wasteful; even the body's agenda are likely to be floundering and further waste the agency's capacities as well as resources.

In a general way, the roles to be presented move from the less to the more aggressive ones in terms of social changes. The exception is the last one of self-survival, which is not an afterthought but a lowly (yet realistic) reminder that there may be no one left to plan if there is no concern at all for self-survival. Each of the roles is further described by typical functions which it encompasses. Again, where relevant and feasible, these functions move from least to most aggressive. In some cases different roles share the same function.

The authors do not agree to the wisdom of all the listed roles, nor do they endorse all degrees of vigorousness under any one role. All of these, however, have been strongly advocated from one or another quarter at one or another time. What authors agree on is that different roles and varying

degrees of functional aggressiveness are called for in working on different issues.

A list of roles and their subsumed functions based on Chapter 10 of H.L. Blum's Planning for Health (2nd Edition, 1981) follows:

1. Agency Management - operate agency well, select agency roles and activities, develop agency skills of influence, timeliness, and choice of strategies.

2. Educator - hearing and exchange of views, issue clarification, general public education and information, education of planning board members, extend community horizons, create value awareness, create goal awareness, open a communications system that overcomes traditional sources of organized distortion.

3. Designer of Planning Technology - adopt or create planning methodology, design and establish policies of own operations.

4. Inquirer - design and popularize the desirability of data collection on social and well-being indicators, measurement, forecast, feedback, evaluation, interpretation, intelligence, place inquiry system responsibility, operate the inquiry system.

5. Assistor and Systems Facilitator - information and referral, advising and consulting, assistance with analysis or design, building cooperation, exchanging information, building coordination, linking levels, linking sectors.

6. Coper and Problem-Solver--Short and Middle-Range Planning - early warning, quick reaction, adaptation, identify health problems, measure size and severity of problems, determine priority rank of the problems, clarify nature of issue within the problem, balancing equity, short- and middle- range design, suboptimizing, satisficing, analyze chosen problems, designate systems boundaries and necessary linkages, design and analyze alternative interventions, design and promote implementation for chosen health sector solutions, influence and promote the implementation for apparently useful non-health sector solutions, conflict resolution.

7. Builder of Futures--Long-Range Planning - forecasting, exploration, exploitation, innovation, experimentation, research, cope with forecasted futures, normative goal design based on projections of current values, normative goal design based on predicted values, normative goal design based on creation of new values, long-range design, optimization, ecologic survival.

8. Policy Planner - design pathways for social change, assist in policy formulation, renew the planning cycle, get policy-maker attention for problems and goals, get legitimization of proposed policies, develop relationships among policy-making centers, develop firm working relationships with policy-makers and those who influence them.

9. Priority Setter - design priority criteria, design priority-weighing policy, apply priority criteria to choice of problems, apply priority criteria to choice of intervention in creating solutions, apply priority criteria to selection of projects for approval.

10. Expander of Capabilities - expand society's operation capabilities, expand individual operational capabilities, harness cross-currents.

11. Advocate - negotiation or brokerage for 1) a client, 2) a goal or belief system, or 3) a means; community organization, lobbying.

12. Activator - for ends, for means (as for resources, action, timing, scope), for placement of responsibility, to generate legislation, to mobilize resources.

13. Power Modifier - identify proximal and real clients, politicize, broaden participation, increase choice, extend community horizons, design strategy, bargain, scandal-proof, maintain power, change or shift power, create power.

14. Controller of Plan Implementation - representativeness of planning board, provision of advice and guidance, moral suasion, creation of guidelines and blueprints, evaluating, overseeing, approving organization and projects, approving financing, establish findings on needs, determine eligibility and compliance, approve permits to fill needs, establish findings on appropriateness of activities of operators, supervise operating entities, administer non-complying operating entities, enforce all aspects of compliance with plans.

15. Regulator, Adjudicator - moral suasion, develop and enforce rules and regulations that are adopted under legislative mandate that 1) provide persuasion or incentives, 2) promote market, or 3) coerce and punish; adjudicate complaints and hear appeals, adjudicate between competitors and alternatives, create rates and set fees.

16. Decision-maker - under legislative mandate make and adopt rules and regulations that have the force of law for any area of 1) health care, 2) health, 3) related areas; exert control over enforcing agencies.

17. Self-survival - looking good, something for everyone, build a constituency, bridge schemes, popularize the "rules of the game," broaden participation, become indispensible, manage the agency well.

## V. Size and Aspects of Systems to be Dealt With

Suboptimizing and Optimizing - As we consider the planning roles, many of them bring to mind the need for determining the scope of the system that is to be attacked in order to get the end for which we are planning. Can health personnel deficits in a low-density rural community be fixed by local banding together to pay providers well above the going rate, or by providing a high level of amenities in order to attract qualified providers? Or will this problem only be solved by new organized systems of care encouraged by a state for all of its under-served areas, rural and urban? Or must we turn to national programs such as the NHSC and to special selection of medical and

other health students who will in fact care to serve there or who, thanks to indebtedness for their education, will be prepared to serve as indicated? Or will we have to have national health insurance with under-served area bonuses so that there will be, without argument, the wherewithal to pay for care (and handsomely at that) in under-served areas and thus no shortage of providers in such places?

It seem reasonable to expect to find under-served situations which will respond to the simplest proposal, that for local change. There will be others in which only the most thorough-going changes such as careful selection, subsidized training, and NHI with bonuses (if needed) for those serving the under-served will suffice. The wisdom required to determine which level of system change is needed is not much farther away than a competent substantive problem analysis, followed by checking the decision arena and political feasibility of the relevant solutions at each arena.

Suboptimizing, in the sense of designing very good solutions for lesser systems, seems totally appropriate in situations that hold no hope for larger system remedies coming about. There can be no justification for nearly every HSA that we have observed ignoring the under-served in its jurisdiction "because there is no motion toward suitable NHI financing." Less comprehensive but modestly effective local programs must be designed if the local situation is indeed a bad one.

Satisficing and Maximizing. When a full-fledged corrective may be quite acceptable politically, it still may not in fact meet all the reasonable criteria by which its adequacy should be judged. It may give us the personnel, but only in the form of a less well-trained person than a physician; it may have a somewhat higher but bearable cost per unit of care or per citizen because of the increased recompense needed to get someone to serve in the isolated areas; it may be care by a person from another culture (FMG) who is the only relevantly technically-trained person who will come. We have clearly not gotten a maximal answer; but if enough bases or value areas are covered adequately, we are satisficing and will settle for such interventions.

Suboptimizing and satisficing can be practiced knowingly in every classroom exercise. They need not be avoided unless they are seen as obstructive to better, feasible solutions. When planners work with those involved in a given issue it is almost axiomatic that those interventions or plans most likely to be attained always satisfice and suboptimize. Not every relevant criteria for each of the involved parties can ever be met, nor can all desirable changes typically be brought about unless we involve local as well as larger or more encompassing systems such as states, nations and the world or nations (think of the issue of the FMG in badly under-served areas of the United States).

## VI. For Whom Does the Planner Work?

Much of planner's behavior, the very issues they notice and the data that they seek, are a function of where or for whom they work. Most importantly, the choice of the word "where" or "for whom", needs to be clarified. We mean who in fact hires, promotes, fires and dictates the areas or work and the breadth of concerns or questions that the planner is free to ask. In many--conceivably in a majority--of work situations, the planner accepts the

boss as the party with whose interests to identify. A little more understanding of the nature of one's boss' best interests, however, may reveal that the boss has no understanding of long-range survival; for example, the blind pursuit of the Secretary's (HHS) guidelines for health planning under PL 93-641 destroyed all credibility and hopes for long-term survival of the HSAs that employ the planners.

Thus matters of apparently no concern to HSAs or SHPDAs (the immediate bosses of many planners) are of critical concern to a wise planner, who identifies fully with their survival but not with the limited view of what needs doing which also preclude their survival. The well-meaning planner who actually has the boss' best interests at heart will have trouble following instructions about his or her scope of activities and what to take into account.

Can planners improve the prognosis for their bosses' survival, as well as for their own job security? Apparently they will need to understand the characteristics of the community system in which they are located, and particularly its relation to the major systems in which they in turn are embedded. Churchman defines and symbolizes the very real forces that "get in the way" of limited or so-called "logical" systems-type thinking as its "enemies." (These he categorizes as politics, morality, religion and aesthetics). The point we and he wish to make is that they are forces that are part of all human systems, forces that must be taken into account if systems thinking is to be anything more than a mechanical and irrelevant chimera of what is at work.

With this introduction of the simplest of planning worlds, i.e., "the planner has the boss' best interests at heart", let us point up the other situations in which the planner might also be working. As with all other subdivisions of this chapter, we do this to identify the kinds of understandings planners will probably need (1) in any given situation and (2) because they also must work or deal with planners from each of the situations to be described, and thus must understand what each of the others must contend with.

A. For publicly-elected policy decision-makers

On the face of it, these planners or policy analysts are working for politically-elected policy-making legislators or executives who have been elected on the inevitable platform of "working for the public interest." More to the point is the fact that the planners are working individuals (or committees, or bureaus or political parties) that mean to keep themselves in power, which might call for planning ends or means somewhat different than the public good might seem to require.

Also, the legitimate public good may be seen in many ways. It may be viewed as providing priority service to those with the greatest deficiencies, as income, health, education, jobs--i.e., focusing on distributive concerns. Public good may be viewed alternatively as the means of aggrandizement of power and resources (accumulating capital) in a few private hands so as to enable strong and large investments which in turn ultimately (and as is currently believed by some) produce the desired distributive effects. Public good may be seen as the aggregation of power and resources in a few public

agencies to do the same thing. It also might better be seen as a varying mixture of such views, changing from issue to issue in the politically more open societies, varying in ascendancy as public and private failures to produce the desired results make us aware of other possibilities.

Planners in the governmental domain may not identify their interests as solely with their political bosses' platform or future, nor with supporters of the middle, right, or left. Perhaps planners favor planning that presages a more equitable future, rather than one which first ameliorates current hurts. More wisely, planners will do both. But how does the planner handle those demands which arise from loyalty to the truly ultimate clients (who also keep the planner's boss alive)? Can the planners reconcile their concerns with those of their bosses' short- and long-term survival needs among vested support groups and institutional support base, all of which may be inimical to the welfare of the ultimate clients or to survival of the country? Issues of ethics bolstered by an understanding of political science, economics and philosophy would seem to be at the heart of such matters.

B. For a governmental planning unit or body

A planner may work for the planning arm of a government agency or even a semi-freestanding government unit (such as SHPDA) which may report to a government agency, or to an elected official via its own governing body (SHCC). In this situation the planner still has the personal and political aspirations of single or multiple bosses to contend with, but is more likely to be shielded from the more blatant private demands of such persons by the statutory framework and civil-service status of many such positions. Ostensibly such jobs have statutorily-defined duties and modes of proceeding which, although limiting creativity, seem to allow more focus on what such jobs were supposed to produce for the ultimate client. If in fact these constraints don't preclude or distort such honorable goals, the planner has at least legal and moral support for being involved with what the planning laws that created the planning agency purported to want.

C. For vested non-governmental entities

The planner's situation would seem the least murky here. He or she is not working for a highly publicized entity with a badly splintered set of supporting and opposing citizen- and vested-interest forces. Whether the planner's work is for the creation of the organization's own internal policy (its guidelines for itself), or for the express purpose of influencing public policy which the organization believes affects its welfare, does not seem to alter the basic nature of the planner's situation.

If the planner takes this job because of belief in what the entity stands for (e.g., its main purpose is profit, a strong union, providing good health care, collecting and distributing charity, etc.) the planner is morally and psychologically hand in glove with the boss. But is this really so? If the boss is an institution, it is likely to have a far from unified policy-setting board, all of whose members have different views about their clients. If it is a trade association, it has small and large, poor and rich, growing and dying members who are very different clients with very different urgent or long-term needs. Moreover, an institutional (e.g., hospitals) planner may quite legitimately see the physician as the major client, the physicians'

patients as the real clients, or the entire citizenry in the market area as the ultimate clients. The planner's loyalties are likely to be stretched. Also, the planner must deal with operations, plans, and planners from the governmental jurisdictions already discussed and must understand their situation.

D. For a group with poorly met needs

The planner who becomes an avowed advocate for an underprivileged group or for a cause probably has the clearest sailing, if he or she is in full agreement with obtaining for them what they want or believe they need. The planner may be paid by them, work for them without financial recompense as a Sierra Clubber does for conservation, or be clearly assigned to serve their planning needs by an outside employing agency. Unless the planner also identifies a larger community or the entire society as the ultimate client, the planner has little about which to disagree with his or her clients. The planner may, of course, question their ends as irrelevant or their means as destructive to large systems and thus ultimately to them. But generally, if the planner takes the advocacy role, his or her work and stance are relatively clear most of the time--except as the constituency comes apart, as it so often does.

E. For a non-profit community-level health planning entity (e.g., a non-governmental HSA)

Such an agency may owe its existance to publicly passed laws or be a voluntarily created entity. In the United States we once had mostly the latter type health planning body with no government participation at all. For the past seven years we have had government as initiator and major resource provider, but the overwhelming majority of these planning bodies remain as private, non-profit entities carrying out their operations at the community level.

This is the real mixing point where, under federal guidelines, such planners meet with representatives and planners of various non-governmental vested interests. To make matters more complex, we have the demographic or mirror-image representation of non-provider or consumer interests on the planner's own board. That these are truly representative of any group's needs is often hard to believe; that they represent all groups in need is even harder to ascertain; that as mirror-image representatives they often have their own immediate vestedness to serve is all too clear--witness the aged, the various categories of the disabled, the ethnics, the rural, and so on. No one is saying that their interests are not vital or legitimate, only that they are vested and not always open to consideration of the needs of others or of the larger society encompassing their own needs. As noted previously, some of these groups may have their own advocate planners to represent them.

What is evident is that the planner in this community-level agency has mighty few supportive constituents, little authority, few resources and plenty of contesting forces to deal with. The planner's direct as well as ultimate client is the Secretary of HHS, who does not (if one is to follow his guidelines) rationally allow for the real ultimate clients, the citizenry of the community being planned for. This is the worst of all planning posts if public appreciation, tangible accomplishments, and a sense of planning well done are planner's rewards.

F. For clients as a consultant

In this situation the planner's client may be in succession, and even simultaneously, any or all of the above types we have discussed. Again, the planner has a contractual boss, short- and long-term considerations, concern for proximal and ultimate clients, and the best nationwide outcomes. In some cases the consultant also has a long-term, but part-time, formal commitment to one or another client. For this planner, much like others, the diversity of interests and concerns to be faced and understood is legion, as are the substantive issues at hand unless the planners restrict their practice to one area (e.g., CON, financial feasibility, or some other reasonably frequent planning activity).

VII. Whose Interests Does the Planner Have at Heart?

A. The employer's

It is easy to say that planners will identify with the interests of their employers. It is just as easy to imagine that planners will frequently if not always have competing loyalties which they may or may not suppress. The following sources of the planner's concern make the point.

B. The planner's

Inevitably planners have their own future to consider. This may involve following their employer's wishes totally--or, more foresightedly, the needs of their employer's clients. What if future advances, better salary, more prestige or more power indicate that the planners should do the kind of a job that earns favorable attention of those who are arrayed against their employers? Shall planners prove how good they are on this job so that the enemies of their agency will woo them away ultimately, or shall they sell out now on a promise of a job? This is further complicated, however, by how the planner's work is perceived by the ultimate clients. They may understand the planner's options and applaud his or her work if it is good, even if the planner's services will be lost to them ultimately. Similarly, they may discern a sell-out and oppose anything with which the planner is associated in the future.

C. The ultimate client with a need

We assume that planners are also likely to have a major concern for their ultimate clients at need. Since these are individuals with a special problem for which planners are planning, their needs should be clear to the planners. This may of course put the planner in conflict with an employer's or the planner's own interests.

What is unfortunate is that the needs of the ultimate clients as a special organized interest group may differ from what the planner perceives as the needs of the individual clients. Where the individual clients are captives to the power of an entrenched interest group, the planner may have to deal with the latter to get anything done at all.

D. Another 'ultimate' client--the paying citizenry

Where planners identify equally with the citizenry at large--the truly ultimate client--they may have large problems because the only available way of helping those of their clients who are in particular need may be so confused and costly that it seems to harm the welfare of citizens generally. The generally muddled and wasteful approaches to health care and human services in this country have driven many planners to jettison the special needs of small groups of highly needy in behalf of the so-called welfare of citizenry at large.

E. Another 'ultimate' client--the society

Where the planner also identifies very strongly with the welfare of the nation as an entity, he or she may, as we have noted, have difficulty in reconciling needs of disadvantaged individuals, or of groups of such persons, with those of the average citizen as an individual--and more importantly with the survival of a "desirable" form of society. This is particularly likely to happen under so-called laissez-faire ideology at one extreme and totalitarian regimes at the other.

Where the planner sees some SEP ideology as the first and foremost concern for society's welfare (e.g., the collective or its opposite, the individualistic society), the planner usually ends up inserting what these views teach into what he or she plans. The ideology may overcome concerns for needy clients, job survival needs, or other potential commitments which we have listed.

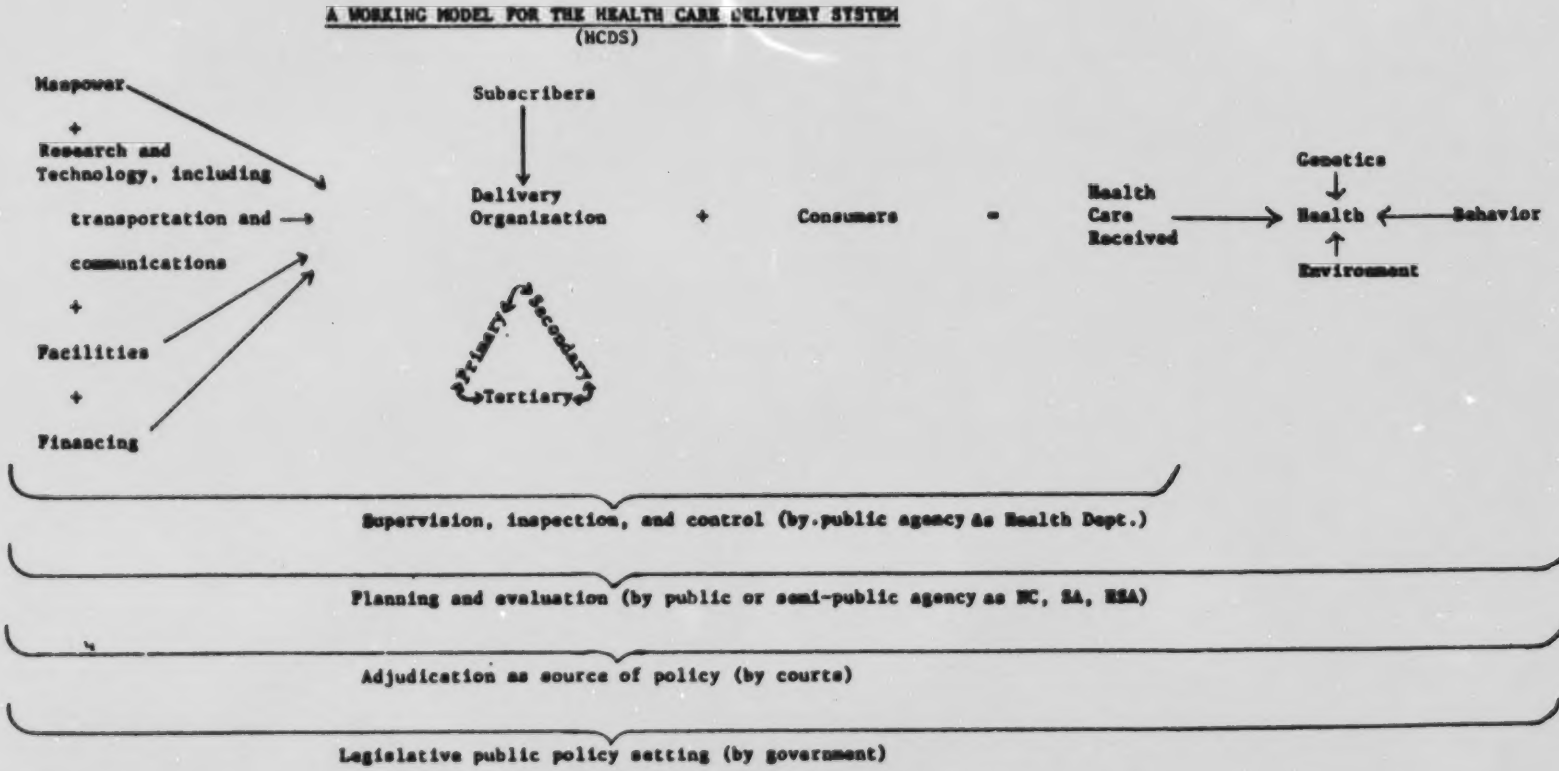
VIII. Planning in Different Subject Matter Areas

It can be foreseen, as presented in Figure B-5, that any one planner might be concentrating primarily on health status of a community. Another at the same agency might be an expert on distribution of health providers, another on health facilities, and so on. Because there can be major tradeoffs between types of providers, or between providers, technologies and facilities, etc., still another planner should indeed be an organizational expert concerned with delivery of health services overall.

It is also readily apparent that the expertise for determining health status is remarkably different from that for any of the service planners, and that each of the latter types may be using tools and concepts quite foreign to other, similarly narrow, planning specialists. Just as Figure B-2 indicates the areas of planning process in which a planner might specialize, so Figure B-5 indicates the many larger substantive aspects of health and health care in which a planner might specialize; many of these are customarily further subdivided into several areas of expertise.

It is not necessary to indicate just how process specialization might further interact with subject-matter specialization. But it is relevant to point up how limited a view a single, highly-expert planner might ultimately develop--even to the point of overlooking that the piece on which he or she is so expert rarely stands alone. Just a change in the license-defined work areas of one type of health practitioners can affect everything from formal training to service delivery teams, financing, costs, competition, and so on.

Figure B-5




Adapted from H.L. Blum, "Planning for Health", Human Sciences Press, 1974, p. 278.

## IX. Choice Among Overall Approaches to Planning

Finally we come to the issue of what planners are really being asked to do. For example, are they being asked to reach heretofore unattained goals or are they to resolve problems which are unpleasant or growing? In the latter case are they expected to prevent the problem or only palliate its consequences so that is will continue as a bearable intrusion? Because communities often describe their problems in terms of some intuitively-derived remedy, the planner may be asked to bring that remedy into being. More commonly, the planner will face the need to work through and contrast several such strongly-competing remedies (none of which may be relevant). In the Medicaid cost crisis one vested interest may be battling for full-pay fee-for-service, another for HMO contracts, and another for cutting eligibility as well as scope of services. Still another wants to offer new kinds of services, so as to be able to shift patients to less costly but more suitable levels of service. The only constraint in common is to hold down the budget.

Sometimes a planner is actually asked to achieve something which has never been done before: "Health Care For Everyone by 2000," "Worldwide Childhood Immunizations by 1990," and so on. Such goals do arise from whole galaxies of current failures, but are finally being verbalized because either suitable technologies and resources are theoretically available, or because the enormity of their absence is weighing on our social conscience and our society's political credibility.

Thus we come not just to the steps of the planning process or the Stages of the social change stream but to the general approach and priorities that are to be assumed by the planner. There are endless classifications, a good eighty of which are presented by Blum in Chapter 10 of the 1981 edition of Planning for Health. What is evident is that nearly all of these described approaches are advocated and get their name because of the role priorities they call for on the part of the planner (e.g., time span, degree of control, use of participation, emphasis on problem or normative states, and so on). Figure B-6 gives a spectrum of eight diverse approaches to illustrate such extremes as present or future orientation, control or laissez-faire, problem-solving or goal-seeking, and so on.

# PART C: THE STATE OF THE ART AND THE FUTURE

## I. The Belief-Value Systems and Constraints to be Dealt With

Planners or policy analysts, no matter how specialized, must see enough of the general thrust of which they are a part if they are to play a useful role in that effort. It will be to no avail that they can do a perfect assessment of health status if the planning effort is carried out in a society that has no interest in such an issue; or attributes health solely to supernatural causes; or, as in our own society, customarily attributes it to medical interventions. Planners must comprehend not just what the society generally believes affects health, but what the society predominantly assumes is its role in promoting health. Beyond this, planners must understand each involved profession's view of the same issues and how these differ from their own. Finally, planners must understand the multiple and discordant streams of

FIGURE B-6

## *A COMPARISON OF PLANNING MODES*

### *PRESENT OR SHORT-RANGE CONCERNS*

| | 1 Laissez faire | 2 Disjointed incrementalism, problem amelioration | 3 Allocative | 4 Articulated & guided incrementalism, problem solving |
|---|---|---|---|---|
| | No planning | Minimal planning | Minimal planning for the present or near future | Planning for the present or near future |
| Planning mode | Leave market unfettered and eliminate need for public programs, private planning unfettered | Apply obvious remedies to undesirable situations as they become intolerable | Allocate resources in accordance with evidence of effectiveness of current programs and meet high-priority new problems | Analyze problems in terms of systems in which they are embedded and design interventions accordingly, select for implementation according to larger social goals |
| "Present" or short-range results | *Problems will disappear* | *Ameliorate present problems* | *Alter priorities and present problems* | *Ameliorate present problems and future ones* |

### *MIDDLE AND LONG-RANGE CONCERNS*

| | 5 Explorative | 6 Explorative | 7 Normative | 8 Total planning |
|---|---|---|---|---|
| | Planning with the future | Planning towards the future | Planning from the future | Planning for all activities present and future |
| Planning mode | Determine and make the most of trends and allocate resources so as to take advantage of what is to come | Explore the futures possible from current trends, capacities, expectations, and design a desired[2] feasible future. Allocate resources accordingly | Decide on the future desired[3] and allocate resources so that programs and trends are changed or created accordingly | Decide on the future and present desired, and lay out use of all resources accordingly |
| "Present" or short-range results | *A sense of its unfolding over time.* Take advantage of what is coming | *A sense of choosing the best feasible desires.* Seek what could be | *A sense of helping create desires.* Seek what should be | *A sense of controlling all desires.* |

[1] Adapted from Rena Kaye, personal communication.
[2] Usually done on a basis of current or predicted values.
[3] Can be done on a basis of current values, predicted values, or creating new values.
Adapted from H.L. Blum, *Planning for Health*. New York: Human Sciences Press, 1974, p. 56-59.

belief in one area and the degree to which they motivate action and will facilitate or prevent any kind of planned action. Figure C-1 points up some of the belief arenas which planners must include in their considerations.

Planners must understand how a given set of beliefs about health determines what modes of intervention can be considered: biologic, therefore exercise; religious, therefore prayer or mediation; medical, therefore drugs or surgery; and so on (Box A, Figure C-1). Moreover, if in their society it is clear that only market forces are to work, no publicly-sponsored interventions will be allowed which would prevent pollutants, hazardous products, and poisonous foods; provide free care for the poor; and so on (Box B, Figure C-1). Admixtures of these two sets of beliefs determine what can and will be considered as issues of concern to a society (Box C, Figure C-1).

A planner must be aware of how health professionals judge a situation (Box D, Figure C-1). Infant deaths mean a set of near-birth interventions to perinatologists and full pregnacy services to MCH professionals, while geneticists will focus on premarital counselling and social workers on better social family relationships. Epidemiologists might urge better feeding for young women at risk; educators may want better teaching for those at risk and for those already pregnant. Radical health reformists may call for full employment and equal opportunities for all. None are wrong, all are partially sighted, and the planner has to orchestrate the increasingly "upstream" string of interventions cited above into a timely and acceptable panolply of interventions.

Planners harness the spectrum of public as well as professional value-belief systems imposed on them by their society by putting all the interests to work in looking for appropriate interventions at one or another point along the way. These lead to an array of substantive interventive possibilities (Box E, Figure C-1) which are elaborated upon in Figure C-2.

The politics screen (Box F, Figure C-1) points up that if one subscribes to the idea that only monetary gains will induce people to do what the plan calls for in the way of substantive acts (e.g., exercise regularly), one may well have to consider financial incentives or education which shows how better health results in savings or new earnings. If one subscribes to a view of the powers of religious faith, one may seek to utilize religious reinforcement or even incorporate avoidance of anti-healthy behaviors into religions as Latter-Day Saints, Seventh Day Adventists, and many others have done. If one believes in educating for awareness and arousable dissonance over unnecessary ill-health, one will turn to the schools, media, and so on. If one believes in moral suasion and peer pressure, one will turn to families, natural groups, work places, recreation centers, and so on to promote substantive actions. If one believes in constraining behavior to conform to a community's avowed policies by enforcement, one will attempt to introduce prohibitions, penalties and other tangible negative pressures for desired behaviors. This can be for proscribed behaviors of individuals or for those of businesses, industries, or even cities which pollute, create hazards, and so on.

Obviously, some societies prefer one or another route, some are very eclectic, and some shift their approaches from time to time (i.e., there are situations in which certain political, economic, and social routes to social change are "in", while others are "out"). Thus our views of what motivates people determines our political choice of means.

Figure C-1 A Society's Belief and Value Systems Inspire and Constrain What Planners Take Into Account in Designing Substantive and Politically Feasible Interventions

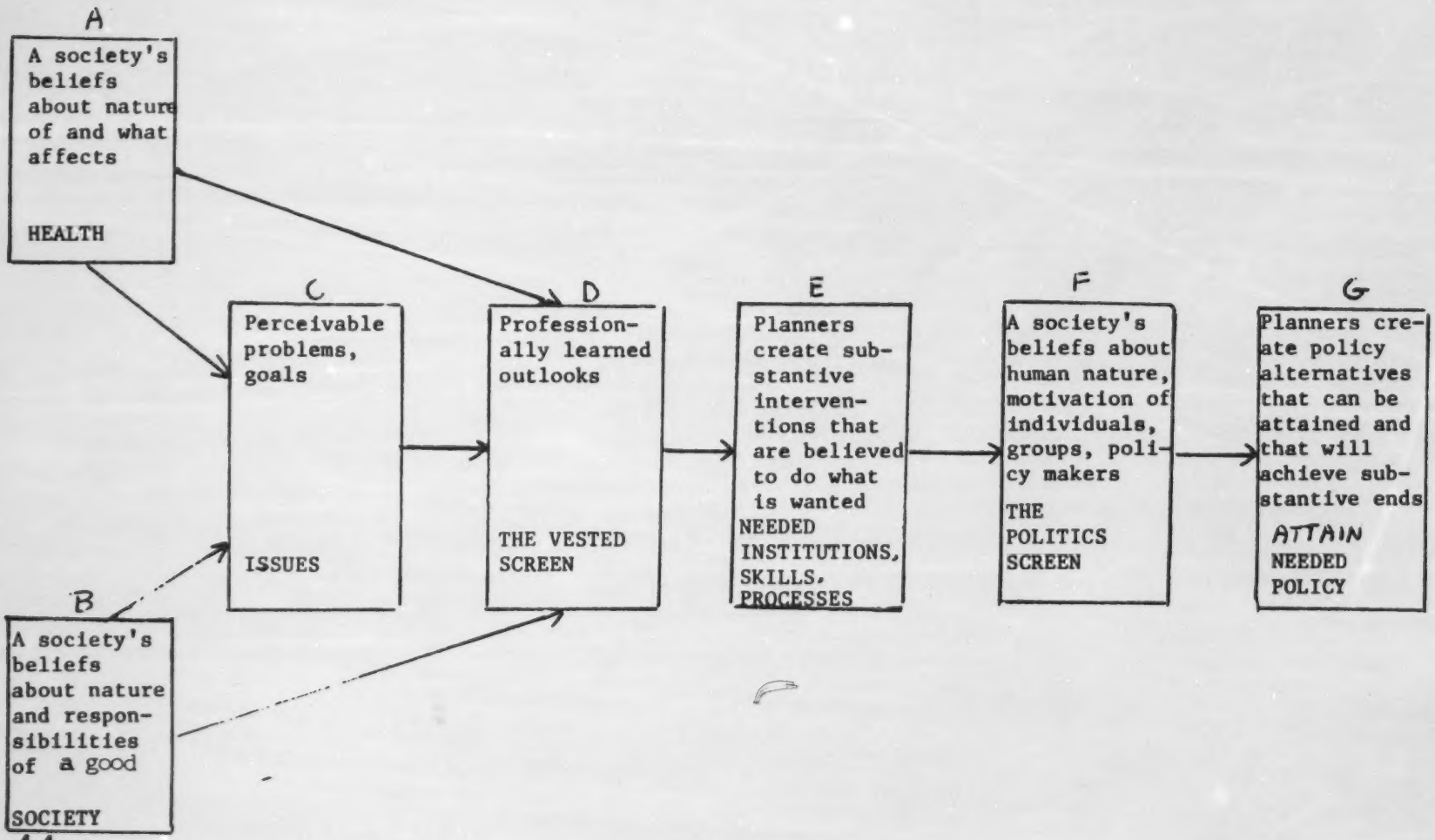
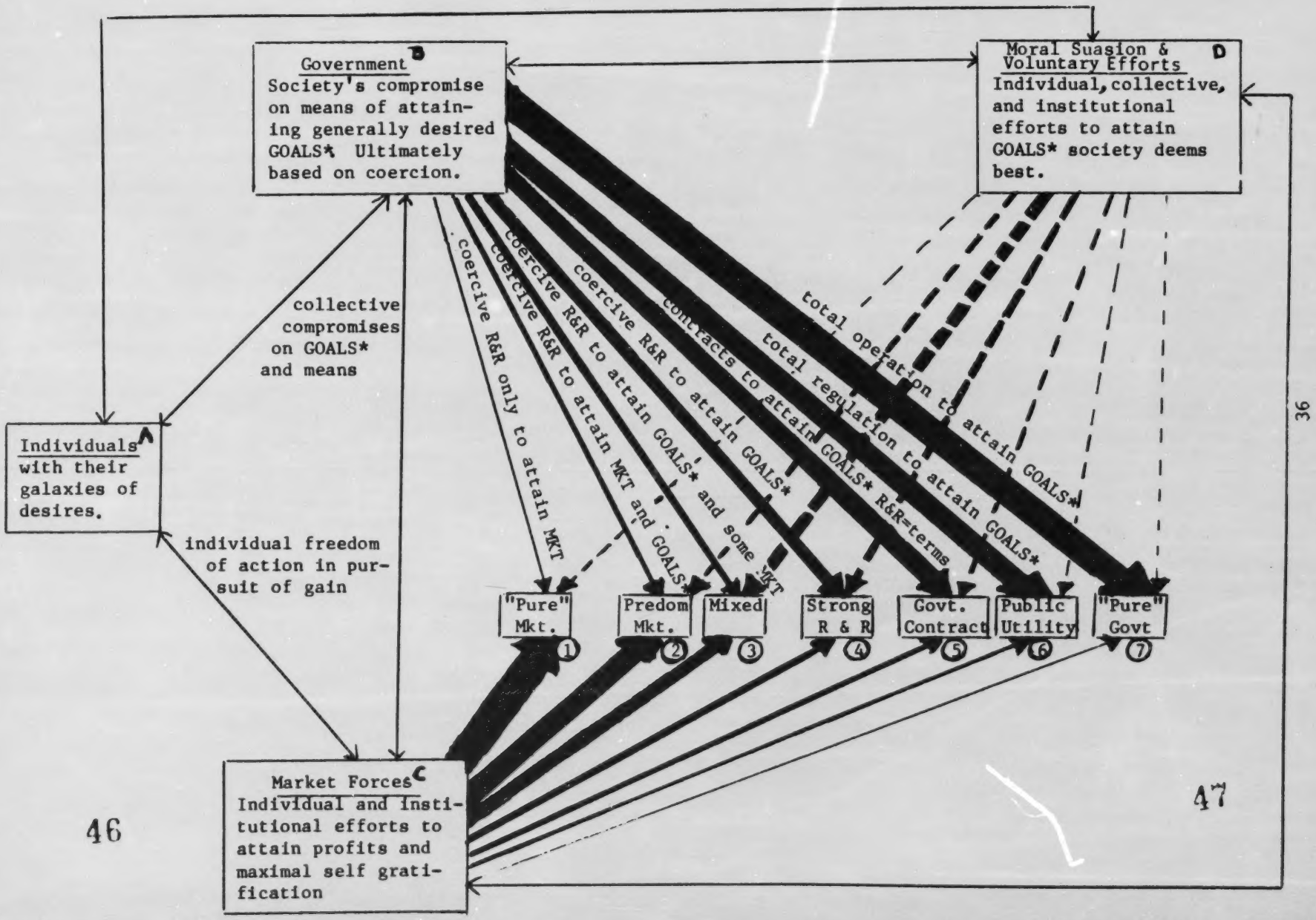

A
A society's beliefs about nature of and what affects
HEALTH
B
A society's beliefs about nature and responsibilities of a good
SOCIETY
C
Perceivable problems, goals
ISSUES
D
Professionally learned outlooks
THE VESTED SCREEN
E
Planners create substantive interventions that are believed to do what is wanted
NEEDED INSTITUTIONS, SKILLS, PROCESSES
F
A society's beliefs about human nature, motivation of individuals, groups, policy makers
THE POLITICS SCREEN
G
Planners create policy alternatives that can be attained and that will achieve substantive ends
ATTAIN NEEDED POLICY

FIGURE C-2

SPECTRUM OF OPTIONS IN IMPLEMENTATION OF SOCIAL PURPOSE
Market Competition, Voluntary Efforts and Government Control

Henrik L. Blum


Government B
Society's compromise on means of attaining generally desired GOALS* Ultimately based on coercion.
Moral Suasion & Voluntary Efforts D
Individual, collective, and institutional efforts to attain GOALS* society deems best.
Individuals A with their galaxies of desires.
Market Forces C
Individual and institutional efforts to attain profits and maximal self gratification
collective compromises on GOALS* and means
individual freedom of action in pursuit of gain
coercive R&R only to attain MKT
coercive R&R to attain MKT and GOALS*
coercive R&R to attain GOALS* and some MKT
coercive R&R to attain GOALS*
contracts to attain GOALS* R&R=terms
total regulation to attain GOALS*
total operation to attain GOALS*
"Pure" Mkt. 1
Predom Mkt. 2
Mixed 3
Strong R & R 4
Govt. Contract 5
Public Utility 6
"Pure" Govt 7

36

46

47

## II. What Every Planner Must Know: A Basic Curriculum

In a rough way we have defined the scope of health planning. As a result, we believe that planners must have a set of basic understandings, no matter how specialized they desire to be or where they desire to work. We further assume that health planners can be trained in a two-year masters program if they have certain basic prerequisites. We base our estimates of allocation of course work on a 21-24 month masters program, of which the equivalent of 4-6 months full time (15-18 months) is spent in class work. Taking the total class work as 100 percent, we will distribute the time in terms of percent among the various subject areas which we believe all planners must (1) be conversant, and (2) have reasonable methods and tools facility. These add up to roughly 65 percent of the 15-18 months of class work. The 35 percent is devoted to more in-depth coverage of either the general areas, or the specialized areas, or some mixture of the two.

Prerequisite education prior to entry into the M.P.H. The following college-level courses should have been completed as prerequisite to entry. Preferably none should be left to do in the masters degree program, for their pursuit will deny the student opportunity to go into more advanced or specialized areas: human biology and disease, psychology, sociology or anthropology, economics, political science, statistics or algebra, accounting and basic computer science.

The basic M.P.H. curriculum. The following content areas must be covered:

A. The causes of social change (one course or approximately four percent of the curriculum)

There are many significantly different theories about what motivates people and how they can be mobilized for social change. Because planners may well work in very diverse environments in their own country, or in many other countries, it is critical that they be prepared to search for the evidence of what does and does not help achieve desired social change in the society in which they are working. Since each of the change theories essentially makes suggestions about what to grasp and use as a lever for getting change, and because each has some empirical evidence to support it, the planner who knows these theories can put them to use, some more in one setting, some more in others.

It is also true that different issues tend to fit in with one theory more than with others. Collective pressures are often more pronounced around hazards occuring to mothers and children. Individualistic pressures are often more evident around provisions of acute medical care.

The traditional economic or Adam Smith view of the "hidden hand" behind the unfettered market place suggests the inutility of most planning. Since the market thereby produces the best of all possible worlds, the only planning needed is that directed to keeping the market unfettered and the consumer knowledgeable (not exactly a small order in any society).

Marxian concepts of change, as well as many political philosophies, ostensibly encourage heavy use of participation and the dialectic process while capital-centered and institutional-capacity models do not. A good many

stress education; most stress opportunities for individual advancement. The individual-deficiency, the economic, the organizational and the societal-failure perspectives are four contrasting paradigms, each of which suggest a different view of what kind of social change is required if we are to have a sensible care system (Riska).

B. The forces that affect health (one course or approximately four percent)

The medical or biomolecular view, the systems or ecologic view, the spiritual, the mechanistic, the homeopathic, and a hundred other conceptual views of what affects our health are in vogue to greater or lesser degrees in various societies and in different segments of our own society. Reasonable familiarity with these views and an understanding of how they affect our approach to servicing health needs is a requirement.

C. The nature and roles of planning (one course or approximately five percent)

A general overview of the major process elements along with an exercise or application of some of the commonly accepted tools used in each step of the process is necessary. A review of the potential roles and functions open to planning bodies under different societal constraints should be scrutinized in the light of the planning process. How the acceptable roles lead into the planning approach which is undertaken should be examined. Subsequently, the planning structures which are needed to support the roles and approach can be delineated.

D. Health services delivery systems (one course or approximately four percent)

Emphasis must be laid on the dynamics of the system and the major subsystems in our country. Comparison to a spectrum of differing systems in other countries is a wise concomitant as it can then be seen how history, tradition, political economy, governance, etc., shape any given system. The options that might be open in any one country can subsequently be postulated, along with the nature of needed enablement.

E. Economics of health services, utilization, marketing (one or two courses or approximately five to six percent)

The study of macro- and microeconomics reveals the theories and the realities of the production, distribution, organization, and utilization of health-related services as a major, but not the only, set of forces that can explain and be put to work to alter any current system of care. Modern perceptions of marketing as part of people-based assessment, and how to go about doing it, can be presented here or separately.

F. Policy analysis, formulation, and implementation (one course or approximately five percent)

The planning which takes place at the policy-formulating and -implementing levels of health planning deserve emphasis because this most critical area of planning is typically neglected by health planners. Issue selection,

definition and analysis, and scrutiny of alternative interventions with emphasis on political feasibility can be taught. Two- to five-day analytic exercises of this sort reproduce the pressures to be met by planners in policy-shaping roles. Classroom creation of one or two major policy instruments, preferably in relation to a real policy setting, would be ideal. The vast span of implementation constraints as well as opportunities can be taught here.

G. Institutional planning and financing (one course or approximately four percent)

The ability to relate operations to capital financing, cash flow, marketing, operational budgeting, and their combined significance as corporate strategy is a necessary skill for planners in the institutional framework, as well as for those in community-level planning bodies. These issues tie together what is and what is not a reasonable approach to constraints on facilities, personnel practices, corporate structure and direction.

H. Quantitative methods and forecasting in decision-making and operations research (one course or approximately five percent)

Although general planning and policy-analysis courses provide exposure to some of these tools, they can rarely provide facility in their use. Whether it is queueing theory, cost-benefit, decision trees, or whatever, a good set of exercises built out of health issues is needed.

I. Human relationships, communications, teamwork, community group work, consensus-building (one course or approximately five percent)

Probably the most abysmal failures of planners can be attributed to their lack of awareness of, and sensitivity to, the needs and views of others with whom they must work closely in any planning effort. Multiple experts must inevitably collaborate on any but the smallest ventures. Similarly, planners must continuously assess (and meet with, learn from, explain to, and be judged by) community groups and official decision-makers. Their insensitivity is legend, their needs huge.

A course is needed that begins with theories about such relationships and then undertakes multidisciplinary "real life" projects in groups working in community settings under group-process experts as well as substantive ones. This effort could be part of the prescribed field work if so organized.

J. Basic administrative methods, organization theory, program development operations, and evaluation (one course or approximately five percent)

Planners often must administer their own shop, and they must also be cognizant of the administrative aspects of service entities. Thus they need to be reasonably familiar with organizational behavior theory, organizational methods, budgeting, personnel, program development, evaluation, and so on.

K. Politics, ethics, law, legislation and policy (one course or approximately five percent)

The endless forces of politics at every level of policy, whether it be its

creation, its conversion into law or into operations, is what the planner must be prepared to work with. Legal tools and legislation are continuously part of that admixture. The role of ethics not only in the political arena but in the shaping of policy and how it affects various actors and interests is an equally omnipresent but badly perceived and neglected factor.

L. Biostatistics and epidemiology (one or two courses or seven to eight percent)

Planners build on the substantive understandings created by epidemiologists and sociologists about our failing health and failing institutions. In fact, their dependence on issue analysis requires an epidemiologic approach. In turn, epidemiological or sociological comprehension requires a reasonable facility with statistics. The planner, although not needing to be an epidemiologist or statistician per se, had better be able to intelligently scrutinize and evaluate the statistics and data-handling which planners must get into.

M. Developing antennae for future trends and avoiding obsolescence (one or two seminars or one to two percent)

Once the students have left school, they may not appreciate how rapidly their stock of what they were led to believe were the latest tools have become obsolescent or been superseded. Also, whole new areas of concern may appear in just a few years. What is of the greatest importance is that the new methods or areas are not allowed to go uninvestigated, so that in five or ten years planners suddenly do not find themselves totally obsolescent and uninformed. By developing and keeping one's antennae alive, one can spot each new area as it gains a foothold. Buying half a dozen books, subscribing to a new journal, going to a few short courses on hot new areas each year, are not too great an investment if they are chosen to bring the planner current with the "new" things.

Since in principle it is not possible to know with certainty what the future will be like, it is important that planners learn how to develop "antennae" to monitor these future trends, possibilities, and needs so that they can seek out special programs to bring themselves up to speed in new areas. We suggest an M.P.H. level course designed to instill this "futures" outlook.

- A weekly three-hour seminar for one unit, given each spring quarter. (Students are advised to attend both spring quarters in a two-year program).

- Students draw lots to cover one journal and one news medium from among the following lists:

| Newspapers & Magazines | Journals |
|---|---|
| Wall Street Journal | Science |
| Fortune | New England Journal of Medicine |
| Scientific American | Planning journals (2) |
| Newsweek | Policy Studies Journal |
| Time | Policy Sciences |
| U.S. News & World Report | Policy Analysis |

Business Week
Kiplinger Letter
GEO
Christian Science Monitor
WHO Bulletin
Los Angeles Times
Co-Evolution Quarterly
National Journal
Washington Report on Medicine and Health
Options

Health Policy, Politics & Law
Economic journals (2)
Political science journals (2)
Sociology journals (2)
Psychology journals (2)
Ethics journals (2)
Etc.

- The seminar is intended to be a "future monitoring" device. Students take turns making ten-minute presentations regarding a "key" new finding or trend that may affect the world of the health planner. Presentations ought to include:

    1. Nature of the information,
    2. Where or how the item will occur,
    3. Its significance over what period of time, and
    4. Where one could learn more about it.

  Each presentation will be followed by ten minutes of class discussion.

- Students bring to class two photocopies of each important item or article they have located (whether they are presenting it to the class or not) that seems of particular significance to the health planner's future. These items can be placed in a loose-leaf binder and made available to the class.

Advanced general and specialized curricular areas. The following graduate level courses, each at the three-to-five-percent level of curriculum, are examples of what should be available for those students wishing to get a better grasp of various areas of special interest. (In aggregate, approximately 35 percent of entire curricular credits).

- health personnel planning
- advanced financial management
- advanced quantitative decision-making tools
- survey technology
- evaluatory methods
- advanced organizational behavior
- government decision-making and resources allocation
- systems theory
- social indicators
- advanced policy analysis
- political skills
- hospital and health legislation
- community and family health and nutrition
- advanced social change theory
- advanced economics
- factors in utilization of health care
- alternative care systems for minorities and other special groups of consumers
- regulation, competition, and voluntary sector options for production and delivery of services and implementation of policy

- technology assessment, transfer, planning
- marketing
- advanced statistics
- advanced epidemiology
- advanced evaluation
- advanced computer use
- planning for developing countries
- forecasting methodology

PART D: SPECIAL CONCERNS

I. The Planner as Specialist: Limitations and Possibilities

How specialized can any planner become? We are all aware that the duties of health planners must be limited to varying degrees. Some never do any planning for health; some never do any planning for health care except insofar as they do data-gathering on facilities or personnel. Some planners do only CON, others AR, and others financial feasibility. Some at the national level are limited to work on guidelines.

The issue really needs turning around: To what degree can a planner safely look forward to specialization? At this point we can easily foresee planners focusing on such areas as finance, facilities, manpower, organization, technology, rate setting, problem analysis, implementation, political feasibility or evaluation. Additionally, will the planner be specialized into work at just one level of government, and on one aspect of the process; and if so, how much of an interface will he or she have with public and private environments?

From what has gone before, we can assume that any given planner might choose to be an expert in any phase of the planning process and limit learning to that one area (i.e., evaluation). Inside that area the planner might further select (i.e., evaluation of status). Such a planner might further elect to work in a limited environment such as an HMO in the private sector or for a public planning agency. Moreover, our hypothetical evaluator-planner might also tend to work only in one state of the United States.

If specialization to this degree is not only feasible but indeed likely to be the fate of the majority of persons employed in health planning, what can be said about specialization in their education? Reasonable expertise as an evaluator might well take one full year of masters-level training and might well be extended through a second year by a mixture of field applications. In fact, evaluation or marketing practices in the community, not-for-profit, HMO setting might take the best part of a year in addition to the more general behavioral and outcome technique approaches needed to work in any evaluatory setting.

What indeed will happen to the immaculately-trained evaluator if a higher-level planning position in that HMO structure is offered? Is it to be taken for granted that no narrowly-trained evaluator can ever aspire to direct all phases of the planning process in his or her setting without going back to school to get a more general planning comprehension? Or is it to be taken for granted that any competent evaluator could expand to do the planning needed?

One can similarly hypothesize about the evaluator moving fron one planning setting to another at the same level (e.g., hospital to HSA), or as evaluator of one hospital to become the evaluator of a national chain of hospitals. And what happens if our evaluator is asked to go overseas (proprietary hospital chains are already becoming multi-national)?

We draw certain conclusions from these conjectures:

1. No process person such as a planner stands alone.
2. No planning entity lives alone horizontally.
3. No planning entity lives alone vertically.
4. No planner need be all things or a specialist, but all must be able to understand roles of other specialists and generalists to carry out their own role.
5. Beyond a satisfying generic understanding that allows appreciation of all specialist roles, any one planner may then pile on a higher generalist or specialist layer of capacities.

We obviously have laid out the masters degree curriculum so that every masters-level planner will be a reasonable generalist. In addition, we have left enough curriculum time (35 percent of the total) so that the basic generalist can either build a fair set of skills in a specialized area or advance on a more general front. The proposed four to six months of full-time, supervised field experience should be spent doing either the specialist or generalist kind of work the student is preparing for.

## II. The Effects of Growing Resource Shortage, Public Mistrust, Bigotry, and Policy-Making Paralysis

At the same time that most nations, including our own, are evidencing a growing inability to get reasonable consensus on solutions to major problems (certainly in part due to our unwillingnesss to ever analyze problems either substantively or ethically), there is growing pressure for adoption of hard-line, large and tragically simplistic means for equally dubious ends. Advocated are a return to naked destruction of our limited resources, or overlooking job and environmental hazards of increased production (much of it for goods that we would all be better off without). Policy-makers stand by helplessly, trying to appear relevant while one-idea constituencies try to wipe out all but the most reactionary and non-thinking policy makers.

Inside of these vast ends what will happen to our health, and what roles should planners be prepared to carry out? Since we are unprepared to say into which ends and which issues planners will be mandated, and which others they may perceive as more important than the mandated ones, we suggest a list of basic issues that no planning body or planner can be sure of avoiding. These are presented in the form of scenarios in the next section. Some of the issues are, to be sure, ones that planners might well wish to avoid in many and even in most circumstances. But these issues are not going to go away by themselves. For example, in an era of hard-lining, more rather than less controlling functions may well come to planners and policy analysts--functions which many feel can only be deleterious to serious planning efforts.

Examples of major roles that planners must be prepared to face and undertake, and for which they must have at least a sense of appropriate tools,

are presented. Many roles have already been listed, and more will peer out from time to time as we guess at the changing work of the planner.

The following are a handful of scenarious to be reckoned with:

## III. Scenarios: What Will the Future Demand of Planners in the Way of Preparedness?

The path to the future can be thought of as a stream running to an undetermined destination. Sometimes the course of the future seems clear and direct: moving onward through eras of ever-increasing nobility and prosperity, or rushing just as directly to perdition. At other times the future's course is vague and meandering, seemingly without direction or purpose, promising nothing but uncertainty and random confusion. But even though the future is unpredictable, it is still inevitable.

Future studies distinguish among possible, probable, and preferable futures (Amara, American Council of Life Insurance). In the discussion which follows, we present ten scenarios describing possible futures for American health policy. Each scenario is described in terms of ten variables (Harman):

1. The state of society
2. How it got that way
3. The organization of the health care system
4. The meaning of "health" (Falcone)
5. Who makes decisions about care
6. Financing of health
7. Vulnerable populations
8. Topical health-policy issues
9. Key powers in health politics
10. Roles of the health planner

We envision three somewhat distinct stages in the future (see Figure D-1). In the immediate future, health policy issues are influenced by society's overriding concern for the economy (Figure D-2). In this era health policy is a subset of economic policy. In stage two, the intermediate future (Figure D-3), health is "rediscovered" as a policy issue with substantive dimensions that extend beyond the economy. Health policy focuses on making the existing health delivery system more effective as well as more efficient. During this period, some sort of national health insurance scheme is adopted, dominated either by the private or the public sector.

The last stage treated here, the long-range future (Figure D-4), describes a world of several radically different possibilities. The historical debate over individualistic versus collectivist values is revised in the guise of a "micro" vs. a "macro" focus on health policy. In the micro world, health is a matter of individual concern and responsibility. In the macro scenarios, health is seen primarily as the consequence of particular social, political, and economic structures. Regardless of how this debate is resolved politically or philosophically, health policy likely will be shaped by both values (Blum).

Figure D-1

Ten Possible Health Policy Futures

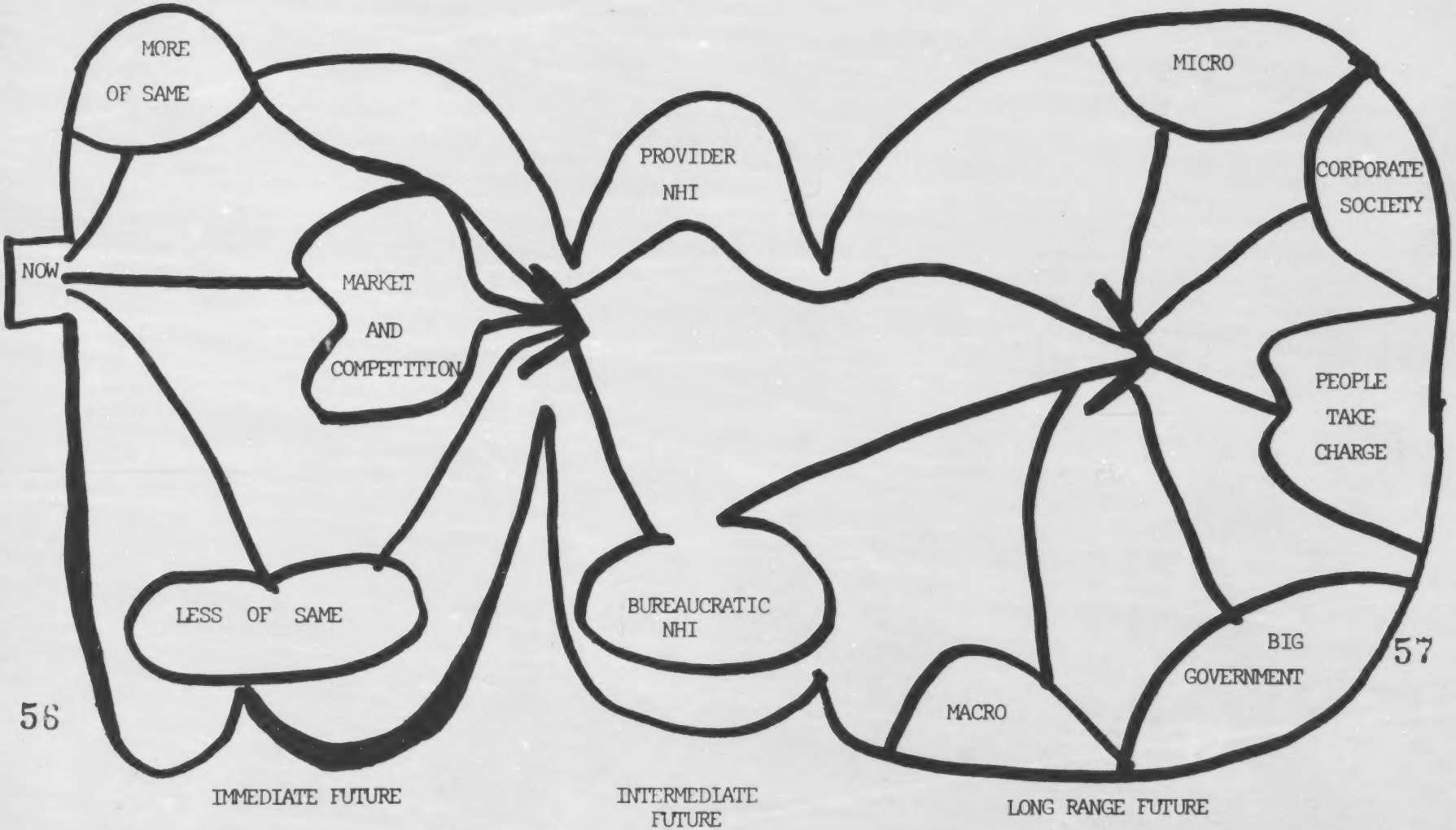


Figure . D-2
CHARACTERISTICS OF 3 IMMEDIATE FUTURES

| | More of the same | Less of the same | Markets & Competition |
|---|---|---|---|
| 1. State of Society | -Uncertainty, fear of the future, Privatism. | -Fear for future survival<br>-Few new ideas<br>-Conflict and terrorism | -Rebirth of U.S.<br>-Entrepreneur is American hero |
| 2. How Society got that way | -Persistent inflation, low economic productivity. | -Deep recession, high inflation.<br>-Public and Private sectors fail to lead. | -Return to Basic principles of U.S. society. |
| 3. Organization of HCDS | -Fragmented, uncoordinated, conflicting. | -Major shift to local and philanthropic care. | -Deregulation, more consumer choice. |
| 4. Meaning of Health | -A commodity to be purchased. | -A luxury | -A commodity to be purchased with money, time, barter, etc. |
| 5. Health Care Decision Makers | -Professional providers, mostly M.D.s. | -Some professional providers;<br>-increase in self-diagnosis or trust in local healers. | -Consumers play a larger role in deciding care they receive. |
| 6. Financing of Health | -Mixed Public and private. | -Decreased in public sector funds; increase in charity. | -Mostly private sector financing (insurance, employment benefits, etc.). |
| 7. Vulnerable Populations | -Uninsured, institutionalized, catastrophic victims, rural & inner city residents. | -Low income, elderly, institutionalized, rural residents. | -Low income, chronically ill, unproductive members of society. |
| 8. Current Health Policy Issues | -High cost of health care<br>-Long term care. | -Reduce gv't. expenditures more,<br>-No or inadequate access to care for many people. | -How to get info to help consumers decide<br>-Access & equity<br>-Environmental damage. |
| 9. Key health politics powers | -Traditional providers; M.D.s, hosp. | -Propriatary Hospitals increase their power. | -Group practice, health insurers, propriatary associations. |
| 10. Health Planner roles | -Regulators, mostly public sector unimportant. | -A dying profession<br>-design & monitor corporate systems | -Entrepreneurs, info disseminators, advocate |

Figure D-3
CHARACTERISTICS OF TWO INTERMEDIATE FUTURES

| | Provider NHI | Bureaucratic NHI |
|---|---|---|
| 1. State of Society | -Trust in experts and specialists for direction<br>-Productivity & efficiency valued. | -Gv't. guarantees basic standard of life.<br>-General welfare valued. |
| 2. How society got that way | -Corporation is model of rational society. | -Federal gv't. reasserted its role in economic and social policy. |
| 3. Organization of HCDS | -NHI, run by M.D.s, hospitals & insurers on "business" principles. | -NHI, run as a public utility. |
| 4. Meaning of Health | -Basic health care is a right of all. | -Basic health care is a right of all. |
| 5. Health care Decisionmakers | -Physicians | -Providers, influenced by what NHI does. |
| 6. Financing of health | -Most financed through Public sector<br>-Cap on expenditures | -Most financed through federal taxes. |
| 7. Vulnerable Populations | -Rural, inner city residents<br>-Institutionalized populations | -Groups not represented well politically - e.g., poor, rural, inner city people, non-voters. |
| 8. Current health policy issues | -Increasing cost of NHI<br>-Dehumanized care<br>-Environmental damage | -Scope of NHI benefits and fees<br>-Repairing environment<br>-Little innovation in health system |
| 9. Key health politics powers | -Physicians, hospitals, insurers | -Bureaucrats, traditional providers, business, labor, ethnic minorities, aged. |
| 10. Health planner roles | -Key roles in system<br>-Assess use, impact of resources<br>-Identify unmet needs | -Designers, evaluators, advocates,<br>-Key Roles in system |

Figure D-4
CHARACTERISTICS OF 5 LONG RANGE FUTURES

| | MICRO | MACRO | NETWORKS | CORPORATE | GOVERNMENT |
|---|---|---|---|---|---|
| 1. State of Society | -Focus on individual responsibility. | -Increased concern for the "whole" society. | -Decentralized, individual freedom of choice & community valued | -Society is another name for "corporation" | -Federal gv't. takes care of everyone. |
| 2. How society got that way | -Reduced dependence on experts | -Recognition of impact that social structure had on society. | -Disenchantment with public & private sectors. | -Corporations controlled economic, then social life. | -The only way to guarantee equality for all. |
| 3. Organization of HCDS | -Organized for clients convenience. | -Expanded focus on health-e.g.,housing, jobs, etc. | -No single type of HCDs | -Run as business<br>-Corporate offices for health. | -National Health Services (re:Dellums). |
| 4. Meaning of Health | -Meaning is responsibility of individual. | -Physical, mental, social, spiritual well-being. | -Depends on local health networks. | -healthy workers needed for effective corporation | -Comprehensive idea of health is a right. |
| 5. Health care decision makers | -Individuals helped by advisors if desired. | -New Health workers and traditional providers. | -Individuals and local health boards. | -Corporate health officials. | -Government health workers. |
| 6. Financing of Health | -Mixed public & private. | -Mixed public & private. | -Varies from all public to all private. | -Corporate budget item. | -Completely public. |
| 7. Vulnerable populations | -Those who do not value health. | -Rural residents<br>-Workers in "unhealthy" jobs. | -People with no satisfying network relationships. | -People with no corporate affiliation. | -People who engage in disease producing behavior. |
| 8. Current health policy issues | -Limits of individual health responsibility. | -Impacts of alternative structures,<br>-Limits of structural responsibility. | -Need for national standards<br>-Health related "externalities." | -Making care more efficient,<br>-Transplanting priorities. | -Modifying national health service. |
| 9. Key health politics issues | -Individual citizens | -Gv't. people, community coalitions, business. | -Local citizens. | -Corporations. | -Government. |
| 10. Health planner roles. | -Advisors<br>-System analysts | -System designers<br>-New Health Worker | -Not all systems use planners | -Corporate employees<br>-Efficiency experts. | -Prepare, analyze & disseminate gv't. info. |

In a third image of the distant future, high-technology care is provided through the corporate sector. In the next picture, disparate health care services are provided by a myriad of local networks. In the final scenario, the United States has a centralized, government-run national health system that provides cradle-to-grave services coverage.

Our scenarios focus primarily on an American context. We have not considered the impact of possible international (e.g., WW III), extraplanetary (e.g., contact with extra-terrestrial life), or other macro-environmental events that may affect our future. In addition, it would have been possible, by assuming different values for the ten key variables we selected for attention, to construct numerous other possible futures. Nevertheless, the images we do present should be taken into consideration in any comprehensive effort to examine future curriculum needs. The health planners and policy makers of the future--if there are any--will likely live in a world containing some elements of many of the future streams we describe.

In these scenarios, the more centralized and coordinated society becomes (whether through economic or social forces), the more we change as humans. Centralization and coordination require stability, predictability and certainty. People are the main barriers to this type of society. But as biomedicine, psychology, information science and other disciplines develop techniques to "help" people become better adjusted to life, the barriers to a "harmonious" society will be easier to surmount. Such techniques will be used first on the clearly ill (cancer patients, those with genetically-related disease, etc.); extended to other groups (e.g., behavioral modification of criminals instead of costly institutionalization); and then to other, less clearly "ill" people in society. There is no necessary point at which this process must end.

From a 1981 perspective, the totalitarian and dehumanizing possibilities of such a future are intolerable. From a long-range future perspective, though, it may not look all that bad.

A decentralized and uncoordinated future society promises to keep us more like the humans we are today. But there will still be problems of inequity, maldistribution, injustice and all the other ills we have had for the last 2000 years that center around differences among people. The substances of these issues may change but qualitatively they will still be there.

From a 1981 perspective, if that is what it takes to keep our essential, untampered human qualities, perhaps those problems are not too dear a price to pay. From a future perspective however, it may be quite irrational to let those problems continue when the means are available for a "final solution." In all of this, health policy plays a key role. For it is in this arena that many of the debates influencing the shape of our future as a society and as human beings will occur.

Some of the images we present are not especially preferable. But if you don't like what the future looks like, you can go out and make one of your own. The future is not predestined. People have the power to act today to influence what happens tomorrow. <u>The study of the future teaches that there can be more to public policy than trying to understand and react to the past.</u>

## IV. Five Sets of Implications of a Changing Environment for Planners (Kauffman, Shane and Weaver)

Most of the students currently enrolled in planning programs will spend some part of their lives working in the twenty-first century. Within the next few years, students entering the profession will spend the bulk of their time in a century that until recently served as the grist for science fiction. One of the major implications of the preceding scenarios is that we cannot know for certain what sort of world the planners will be living and working in. The last several decades have witnessed a knowledge explosion unprecedented in human history. If the future continues to evolve at this exponential pace, we can expect the next few decades to bring us several centuries worth of change, measured in historical terms. These obvious facts have some profound implications for the way planners are educated and for the roles they will be asked to play.

Survival and success in a stable environment require remembering what concepts and skills worked in the past. In this environment, education is largely a process of transmitting old knowledge to new generations. When an environment is as unstable and as change-prone as ours, survival and success depend on the ability to distinguish what is useful and relevant from the irrelevant, to "unlearn" what is outmoded, and to quickly and purposively adapt to or help shape the new environment. As Kenneth Boulding phrased it, "In a period of change it's the adaptable rather than the well-adapted who survive."

People who design curricula for future planners are faced with the task of preparing students for jobs which do not yet exist and whose duties cannot be predicted with any degree of precision. The utility of a curriculum designed to transmit specific knowledge and skills (e.g., planning law design, zero-based budgeting techniques, cost-benefit analysis) obviously will be constrained by an unpredictable environment. Since we cannot in principle know what specific knowledge and skills will be needed by planners in the future, education has to shift its focus from instruction to enabling. We need to provide students with the will, the tools and the judgement to enable them to instruct themselves.

The future-oriented, "enabling" planning curriculum ought to include at least five major concerns: personal competence, learning how to learn, general welfare, using power, and alternative learning environments. All of these should be built into the various basic dozen courses already described rather than be the subject of special courses.

### A. Personal Competence

Personal competence refers to an individual's ability to recognize and achieve his or her optimum human potential. The basic premise here is that all people are born with the right to develop. Because people are different, their education cannot easily be standardized. Individual strengths have to be identified and built on, through a liberal offering of elective courses, selected in consultation with someone who is an advisor in more than name only. Weaknesses too have to be recognized and brought to a student's attention, not to punish or criticize, but as a prerequisite to self-knowledge. The process of learning will be a more valuable tool for

developing personal competency than the specific products of learning. Thus students should be evaluated against their own educational and professional progress. Little purpose is served comparing a student to a group norm and assigning grades on that basis. Expected lower school enrollments should make it easier for instructors to do this major time-consuming task, unless faculty positions are cut back more stringently.

Specific courses in the curriculum should be given the objective of emphasizing acquisition of knowledge as to which learning style, strategies and environments work best for a given individual; the human relationship and inter-group skills; self-knowledge; self-motivation; time management and stress control.

B. Learning How to Learn

Learning how to learn refers to an individual's ability to find out what he or she did not know before. The basic premise here is that this skill is required because knowledge increases faster than any set of institutions can transmit it. Learning how to learn involves knowing what has to be discovered, and why; knowing how to discover (or invent) what is needed; and knowing what to do with it. It also involves the ability to unlearn, or forget, outmoded knowledge.

Specific core courses in the curriculum ought to be selected to emphasize thinking, information-gathering, communicating, decision-making and judgement. Thinking includes asking questions, discussing the "undiscussable," clarifying values, rational and creative problem-solving, inventing alternatives, recognizing propaganda, probability and statistics, system theory, computer programming, logic, futurism and forecasting. The information-gathering component should attend to how to gain access to information. This includes reading, listening, observing, experimenting; using specialists and experts, reports, computer data bases, references sources; assessing reliability and value; and managing information overload. Communication skills include: speaking in formal and informal settings, body and non-verbal language, writing, outlining, visual communications (graphs, picture, charts), electronic communication, and barriers to communication. Decision-making and judgement skills include much of the material already discussed as basic in the core curriculum. They need a special emphasis on methods for treating uncertainty and risk. Each course should use group-based work projects and, if specific problems are being addressed, options for half a dozen or so possible futures should be considered. This will stimulate thinking and promote cognitive flexibility.

C. The General Welfare

The general welfare refers to the view that the individual ought to be concerned about his or her relationship to what has been called the general welfare, public interest, or the common good. A central assumption here is that individual needs and wants ought to be served in a general-welfare context; that is, both individual freedom and the public interest ought to be maximized.

Specific courses in the curriculum should be designed to help identify the elements and outlines of what constitutes the general welfare. This would involve the sciences courses so that students could come to understand their relationship to the physical and social environment (e.g., biology, economics, politics). Courses should expose students to questioning and analyzing existing social, political and economic arrangements. Because we cannot know what the future will be or what form of society is ultimately the best, the clearly bad or unjust society can be avoided only so long as the conflicts between different conceptions of a desirable society are kept alive. Students need to be always prepared to ask of society, "Is there something better?" This emphasis on exploring alternative value-based arrangements of society is one way to minimize the likelihood of becoming stuck in a future which is conducive neither to the individual nor to the general welfare.

D. Using Power

Using power refers to the ability to get others to act, implement or produce an effect that would otherwise not have occurred. The major premise here is that planners have responsibility to focus on outcomes when a course of action is clear, and to facilitate the discovery of desirable outcomes when the solutions of problems are not as readily apparent. Both activities involve the use of power. This component of the curriculum comes out in such courses as social change, planning, policy, politics, human relationships and administration.

E. Alternative Learning Environments

The idea of alternative learning environments serves to highlight the emergent recognition that education is a life-long process, not something restricted to a few years in an academic institution. Our key premise here is that the structure of the process, as well as the content, has to change if students are to be provided with an enabling education.

We identify five sites at which planners could be educated; home, work, community, professional gatherings and the traditional academic setting.

The rapidly-expanding home computer and cable television technologies, along with the decreasing costs of hardware, offer the potential to turn the home into the learning center. Rising transportation and energy costs, competing demands on a person's time and the need for individually-tailored curricula all suggest a scenario in which people will be able to spend a few hours a week at a time they select, developing and improving skills or catching up on the latest developments in their field. Curriculum designers need to direct their attention to the opportunities and limits these new technologies and their attendant software provide for a planner's education.

The work place has long been recognized as the place where a planner's education "really" began, the place where academic theories were modified or replaced by demands of the "real world." On-the-job training will continue to be a primary source of the planner's education. Curriculum should be designed to initiate (via an internship program) and incorporate work experience formally into the learning process. There needs to be more attention paid to planning student's experience and using feedback from the work setting to improve both subsequent individual learning and curriculum design.

Consideration should also be given to the fact that the bulk of the educational process over one's lifetime occurs on the job. Therefore, for lower-level or mid-career types who wish to periodically upgrade their knowledge and skills, continuing education, organizational development, team building, and other special task or process-oriented courses could be offered at or near the work place by individual consultants, academic institutions, or private or public-interest consulting firms.

The community is another place where planners have been and will continue to be educated. This setting provides ideal opportunities to develop the personal competence, power and general-welfare skills described above. Perhaps more importantly, community involvement--whether at the neighborhood or the national level--provides the university with a link vital to any effort to influence the shape of the future. Further, not only can planning students provide the community with skills and resources they need, but community members can also use the university (via continuing education and non-degree programs) to develop knowledge and refine skills they wish they have. Being able to demonstrate a continuing utility to one's environment plays no small part in helping an institution survive.

Professional associations and networks serve as a primary continuing-education component of the planner's life-long learning program. Professional groups are the originators of special knowledge, provide personal measure of effectiveness and competence, and are the source of and clients for curriculum materials required for enabling education. Students should be expected to participate in such associations while in school.

Schools, the traditional site for professional planning education, obviously have an important role to play in future education. In addition to courses that are best taught in a classroom or lab, planning schools can also serve as an "educational clearinghouse" for planners. In this role they can identify the range of education opportunities available to planning students (home, work, etc.); help students design the individual aspects of their curriculum; and monitor the environment to recognize and prepare for changes that inevitably will have to be made to the basic curriculum.

Students should have the chance to work in several different types of school(ing) settings as teachers and as participants. This will help get across the basic message that learning is a flexible and life-long, part-time or episodic activity.

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RESPONSE

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## Introduction

It is a pleasure, although a challenge, to be able to respond to Dr. Blum and Dr. Bellavita's presentation, "A Curriculum in Health Planning: An Approach for Today and for The Future." The utility of their conceptualizations and the logical flow of their development of a curriculum in health planning make criticism--even constructive criticism--difficult, and so I begin by indicating my strong agreement with most of the health planning curriculum content-areas that they present. I shall focus upon the curriculum of this paper in my remarks.

In my few remarks, then, I would like to examine and discuss two major issues brought out in their discussion: first, to note the similarities between community health planning and health planning at other levels; and second, to relate the curriculum in health planning to that in health administration. In the last part of my remarks, I would like to reinforce several ideas which have been presented in terms of their importance for the academic portion of health planning education.

## Health Planning vs. Community Health Planning

It is noteworthy that the authors did not need to focus on community health planning in order to develop the conceptualizations in the earlier sections of their paper[1] or to lay the groundwork for the curriculum in the third section of the paper. While one may consider this a criticism--that they did not focus on the community level of health planning--in reality it is not. Their typology and conceptualizations are most useful in understanding health planning processes and the alternative roles for the health planner. The point is that these conceptualizations lend themselves to analysis of health planning and planners at other than public-sector community levels. They need not be specific to a particular setting but are generalized to any planning environment.

With this observation, the issue remains as to the differences between the preparation of students as health planners at community levels (public sector) as opposed to the policy level or the institutional level. It might be implied that health planning at the community level is not necessarily different in terms of the curriculum content-areas as just presented, but rather that what is different are the specific examples and cases which are articulated within each of the curriculum content-areas. For example, each of the following are important curriculum content-areas for health planners, but the specific form of their classroom presentation differs depending on the planning environ:

1. accountabilities, responsibilities and delegation (e.g., formally vs. informally defined);

2. power and power structures (e.g., medical staff vs. medical society interaction);
3. formalization of control and power (e.g., hospital policy vs. law and regulation); and
4. definitions of the domain of the planner (e.g., service area vs. jurisdictional bounds).

Given that there are both similarities in curriculum content and differences in applications of the curriculum content, how does one educate community health planners?

There are at least two different ways in which the education of health planners can be designed. On the one hand, all health planners may have the same courses but with different applications and examples for the community level, institutional level, and policy planning. On the other hand, different curricula may be developed for each type of health planner. While we do not have at this time a specific answer regarding which form education for health planning should take, the very fact that we have focused our presentations here on four different levels of health planning and asked our speakers to develop four different health planning curricula suggests that we have already decided that health planning should be taught in different curricula for different levels of analyses. This may be a premature conclusion.

## Health Planning and Health Administration

The paper's Figure B.2, Elements of the Health Planning Process, offers a conceptualization of the generic health planning process which looks much like the management process. Several examples of the management process appear in the health administration literature,[2] and they greatly resemble this figure. Given this similarity between the health planning process (assessment, analysis and design, implementation, and evaluation) and the management process (planning, development, implementation and evaluation), and given the fact that the health planning curriculum evolves from such a conceptualization of the health planning process, it is not surprising that the curriculum for health planning (as presented here) and that of many health administration programs look very similar. Drs. Blum and Bellavita have indicated distinctions regarding the separation of planning from administration, but it appears that the effective health planner needs to know both planning and administration, i.e., he needs to know his own domain as well as that of those who will be implementing the plans which he is able to articulate. At the same time the health planner must be cognizant of other planners and administrators about him who will affect his ability to create change.[3]

This observation supports the necessary similarity between health planning and health administration curricula. It implies a possible close marriage between graduate and undergraduate education of professionals in these fields, rather than an attempt to split these very similar educational curricula.

## Specific Issues

In concluding these remarks, I should like to focus on several specific issues which have been raised by the speakers. Early in their presentation

they referred to "the rich political ecology involved in effective health planning." With this statement they begin their articulation of health planning as both an art politic and a science of technological skills and knowledge. Their conceptualization of planning as both art and science is a major and important observation for education for health planning. In the past, health planning has focused too strongly on either the art or science but not on the interrelationship between these as necessary requisites for effective health planning.

The second major point is the observation that both fact and value are necessary data and information for manipulation by the health planner. The effect of the belief-value systems and the constraints to be dealt with have been identified as major content-areas for the education and practice of health planning. The speakers distinctly noted both of the above issues when they stated "the health planner . . . (must be) alert to his place on the SCS (social change stream) and how the planning process works at that niche; he must take into account the realities of how his society works, what it believes in, its resources and governmental structure."

Third, the presenters have noted the many roles of health planning and have suggested that the planner may be a policy formulator, analyst and implementor. This suggests that the role of a health planner may be a frustrating role for the individual who has not been educated to understand the full range of his capabilities. Education for health planning must focus on all of these roles and, at the same time, must appreciate that the planner is not the all-knowing decision-maker but the guide for planned change. This suggests a close interrelationship among education for health planning at all levels and health administration.

The final issue regards the level of specialization which should be designed into a health planning curriculum. The observation of the speakers is clear--"every masters-level planner will be a reasonable generalist"—but with fifty percent of the curriculum for either specialization or advances in general skills, some planners can become reasonable specialists too. It is questionable whether a curriculum with only half of its content labeled as "generalist" can actually produce a reasonable generalist. Without refuting the discussion on health planning generalist vs. specialist, I would raise the concern that some additional courses which have been suggested as elective and specialty might be considered required courses for all health planners as part of their generalist education (e.g., human resources planning, hospital and health legislation, marketing, and forecasting methodology). In addition to these, a full course in ethics in decision-making would bring the health planning curriculum to seventy percent generalist and still allow thirty percent for individual planners' special needs.

In conclusion, I shall raise a final point. It is a caveat that we health planners should take care first to define ourselves and our profession (along with the body of knowledge that is that profession) before we begin to create our own specialization and diversification, the results of which will be a fragmentation of what needs to be at this moment a unified and emergent professional identity and body of knowledge. Our rush toward specialization is premature; our thrust should be towards the development of a collective identity through development of the knowledge base of health planning and its curriculum.

FOOTNOTES

1. Except in their development of Figure B.1 Stages of the Publicly Planned Social Change Sequence, and as it is articulated in Figure B.3.

2. R.A. MacKenzie: "The Management Process in 3-D," Harvard Business Review, November-December 1969, pp 80-87.

3. C.L. Breindel: "The Myth of Micro and Macro Health Planning," Hospital and Health Services Administration, Summer 1980, pp 38-47.

RESPONSE

by Dean Montgomery
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Discouraged with current political attitudes toward planning and with the state of planning affairs generally, Drs. Blum and Bellavita are hopeful that better-trained planners will make a difference. As a step to this end they have suggested a two-year masters program that they hope would give aspiring planners "a set of basic understandings" which would prepare them to enter a variety of planning settings and begin educating and applying themselves to the task at hand.

The curriculum proposed appears to be a judicious mixture of the necessary practical courses, seasoned with a modest number of courses on contemporary social problems, social change theory and politics. Acquiring this background presumably would permit the student to find a reasonably comfortable niche for himself as a general-purpose or specialty planner. This certainly is a reasonable approach and undoubtedly offers improvement, if accepted, over what is the standard fare in most graduate schools.

But frankly, the curriculum described is much less interesting than the rationale given for it. Perhaps any two-year program that seeks to impart a basic understanding of a complex subject must of necessity be more conventional than not. The curriculum proposed includes four to six months of field experience and fourteen to eighteen months of classroom work, about half of which would be required courses and about half from elective specialty areas. Most of the courses suggested are now offered in some form in most graduate planning/administration programs, but they probably lack the coherent theme that the authors seem to suggest is necessary to get full benefit from them. That is because most graduate programs lack the vision, the organizing principle, that permeates the authors' rationale for the courses. They hold, correctly I think, that planners should recognize that planning involves both normative and practical aspects. They also assert the fundamental principle that "beyond question, the overriding purpose of planning is to obtain social change." This assertion may seem tautologous, but it is like a breath of fresh air to those working in stale environments where either word "social" or "change" is viewed with great suspicion. Like the proverbial response of the man on the street when read the Bill of Rights, it is highly probable that most practicing planners today--certainly the majority of those in Health Systems Agencies and State Health Planning and Development Agencies--would not endorse that statement in daylight. The fact that it is a basic premise to the authors, and that they suggest that courses on the varieties and means of social change be part of any acceptable planning curricula, is to be applauded. It is no small matter.

By bringing to their proposed curriculum the organizing principle of the planner as social change generator and manager, Blum and Bellavita impute to planning a much-needed sense of mission. Any laborer needs a sense of purpose, and this is particularly true of those engaged in relatively new, somewhat amorphous tasks such as health planning. Uncertainty is an occupational hazard among planners, but the lack of confidence and resultant trepidation so

evident among health planners generally is crippling in many instances. A curriculum such as that proposed, energetically applied, might go far to instill more optimism and dedication to purpose in graduates. It surely would help them to place day-to-day planning problems and set-backs in a much broader perspective--or, to use the authors' term, would enable planners to determine their location on the social change stream, their position relative to the rest of society. One hopes this attitude, carried to the classroom, would prove infectious.

One surprising aspect of the proposal is that there was not a greater effort to suggest what, if anything, is unique about planners and then try to strengthen that asset by giving greater emphasis in the curriculum to courses that would nurture it. If that is done at all it is in the area of human relations. The authors believe "probably the most abysmal failure of planners can be attributed to their lack of awareness of and sensitivity to the needs and views of others with whom they must work closely in any planning effort . . . Their [planners'] insensitivity is legend, their needs huge." Planners certainly are at least as inept in human relations as any other group, and it certainly is true that effective working relationships and a sensitivity to the needs and views of others is necessary for effective planning. But it is doubtful that it is this deficiency--which certainly is no less evident in physicians, teachers, hospital administrators, lawyers, etc.--that leads to our more striking failures or our more serious weaknesses.

Rather, the planner--unlike the teacher, the lawyer, or the physician--has yet to convince the public of his social utility, his justification for being. The public will tolerate a modest amount of insensitivity out of someone they think to be essential or otherwise valuable. How else do we explain the professional reputation and social status of lawyers? The planner has yet to convince society that he is valuable, much less essential. That educational effort should be a priority, and should result primarily from concrete actions rather than public relations.

Fortunately, there does seem to be one critical asset that the well-trained, motivated planner has that presumably is possessed by few others: he is better able than others to forecast the future. From time immemorial deference has been paid to those who could predict the future, or at least were foolhardy enough to try. Planners should at least have the temerity to try. Present forecasting techniques are sufficiently developed that if properly used and interpreted they can give relatively reliable predictions. For this reason, it seems highly desirable to place much more emphasis on forecasting methods, strategies and philosophies in graduate planning curricula than has been the case heretofore.

It must be stressed, in fairness to the authors, that they do not neglect forecasting concepts and techniques. These are presented as necessary components of a health planning curriculum. But the reader does not gain the impression that the authors have tried to identify, and then maximize, any unique technical quality inherent in planning that distinguishes it from, say, administration or management. It seems that such an effort would be worthwhile and need not detract from other aspects of the curriculum. One would hope that future proposals will contain as much emphasis on specialized analytical techniques, especially forecasting, as the current proposal's emphasis on interpersonal and community relations.

As has been noted already, the distinguishing feature of the Blum-Bellavita proposal is their effort to mix appropriately practical problem-solving training with education in normative planning concepts and values, to combine the practical and the ideal. This attempt is commendable and one assumes it will succeed. It would be even more interesting to see the authors take their approach one step further, expand their consideration of the normative aspects of planning, and suggest that planning itself represents an ideology, or is more compatible with some ideologies and values than others. This might lead to an elaboration on the authors' theme that planners exist to bring about social change. Can planning be used to bring about any type or form of social change, or does the application of planning ideology result in not just social change but predominantly changes of certain types or directions? Is planning education and training dedicated to bringing about social change by definition a "subversive" activity, requiring special skills and talents for success? These considerations, if acted on, probably would entail that one or two "philosophy of planning" courses be required. The nearest thing to this in the proposed curriculum is the course in ethics, which though highly desirable may not be sufficiently focused to deal with some of the underlying philosophical problems inherent in the training of planners.

It must be stressed, in conclusion, that the criticism offered here is marginal and hardly detracts from what is a solid yet innovative proposal. The authors are to be congratulated on their effort, largely successful, to blend practical requirements with highly desirable offerings in social and political theory. The only basic question that should be raised about the proposal is whether it is structured to delineate sharply enough the essential differences between planning and administration or management. That is something all health planning programs need to consider carefully. Artificial differences need not be manufactured, and unnecessary and arbitrary distinctions should not be drawn; but legitimate differences need to be accentuated carefully and consistently if we want predictable results.

DISCUSSION SUMMARY

by William D. Greaf

This paper summarizes the responses to papers presented by Henrik L. Blum, M.D., M.P.H., and Christopher Bellavita, Ph.D., on the topic "Curriculum For Community Health Planning." It is impossible in an effort such as this to capture the subjective intent and innuendos of these verbal responses and to report them in a truly "objective" manner. Many of the questions asked by the conference participants have also been included. Often questions asked are more revealing and important in the long run than the initial answers to those questions.

One of the first questions which must be asked (and answered) before suggesting a curriculum for community health planning is what is (and will be) such planning? What areas will such planning examine? Will the public or private sector be responsible for and accomplish such planning? If the public sector, which level of government will undertake community health planning? Will there be major changes from current health planning efforts? Will community health planning continue to be practiced to any degree?

Many of the conference participants agreed that health planning, as it is known today, will not continue to exist. It was anticipated by some participants that community health planning will be accomplished at the state government level instead of the current regional (albeit federally-imposed) level. This would create the need to train state personnel to cast aside their state perspective; this would not be an easy task. Other participants stated that without a federal initiative, the number of organizations (agencies) conducting health planning activities would be reduced; however, the health planning efforts of these fewer agencies might be of a higher quality since they would not be using federally-required mechanisms and would be composed of persons who wanted to, and (it is hoped) could, enhance health planning.

Other participants stated that current health planning efforts will undergo a thorough review in the near future. One of the probable results of this review is a diminished role for regulation in health planning efforts and a return to viewing institutions, vested interests, etc., as partners in the health planning effort--and, thus, a return to the practice of coalition-building. Another likely result of this review is different forms of planning conducted at different levels. Community-level planning will be accomplished much more vigorously than in the past.

Several participants, however, expressed a somewhat different view. They stated that instead of a return to earlier forms of community health planning, the new forms of planning would reflect a greater interest in what is currently known as corporate or strategic planning and a merging with other types of planning, e.g., social planning. The result would be a more generic form of planning and a curriculum devoted to the logic of planning.

A second series of questions arose concerning who undertakes community health planning, and thus which students should take health planning courses. The general consensus appeared to be that the vast amount of community health planning will be accomplished by individual organizations with the specific

purpose of conducting planning. This is not, however, to be construed as meaning that no other persons will be either engaged in, interested in, or affected by community planning. Thus, institutional planners need to know what community health planners are doing, especially since hospitals are increasingly viewed as community institutions. Health policy analysts were also specifically identified as requiring a general knowledge of community health planning.

Health institution administrators were repeatedly singled out as requiring an understanding of community health planning and the role of community health planners. It was stated that administrators cannot work in a blank space and they are currently realizing that their institution's environment is much larger than they had realized in the past. The community is part of this larger environment. Also, any good administrator is already familiar with the community as determined by his or her environmental assessment process. Additionally, individuals often switch careers throughout their professional life; switching between the careers of planner and administrator is especially prevalent in the health field. Because of this, students in both career paths should receive some training in community health planning. Also, the planning and management functions are intertwined as stated in most management texts. Thus, administrators cannot be successful without carefully managing their resources and planning efforts.

Related to the question of who should be trained in community health planning (i.e., administrators, planners, policy analysts) is the question of how to teach community health planning (i.e., a separate curriculum or inclusion in another existing curriculum). The participants nearly unanimously believed that planning should not be a separate track but rather should be included in the more traditional health services administration curriculum. Two major reasons were given for this opinion. First, it was stated many times that planning is a key part of the management function and should not be separated from it. Creation of a separate planning track would imply that planning is separate from management and administration. Second, and possibly more important, a separate planning track has the potential for developing a split ("them-and-us" attitude) between planning and administration students. Such a split does little to create a working relationship between the two groups later in their respective careers.

A related question is how much of the health services administration curriculum should be devoted to planning? One semester? Two semesters? Furthermore, should planning be a separate course(s) or should the subject matter be presented as part of administration courses? No consensus was reached regarding these questions.

Many participants believed that the planning component should be presented in a separate course or courses. This would increase the student's ability to comprehend the subject matter. These separate courses would probably be aimed primarily at those students who wish to become health planners, but would be open to other students because of the interface of administration and planning and the intermingling of career pathways discussed previously.

Another possible approach to providing the necessary components of a planning emphasis is the use of other schools' as well as other universities' course offerings through a consortium or other multi-institutional

arrangement. This would provide the student with a wide array of course material to meet his or her individual needs and with the multi-disciplinary approach characteristic of many planning curricula, but would not severely strain any single institution's resources.

Probably the most important question in discussing the community health planning curriculum is what specific course content should be included? Generally the participants focused on two areas. First, the content of planning courses was discussed. Second, courses (or at least their content) from other disciplines and areas of interest were discussed in terms of their appropriateness for a community health planning curriculum.

Initial discussion centered on the content of specific community health planning courses. They should provide a method for determining community wants and needs, as well as providing some guidelines for selecting representatives of the community who are truly representative of the community and not a single interest or individual. It became apparent, however, that it is very difficult to determine who represents the community. Because of a lack of political clout, political expertise, and a knowledge of the health care system, the under-served will often be under-represented in any delineation of the community's needs and wants.

Many participants stressed that the planning courses should address generics instead of concentrating on community health planning techniques or other specific forms of planning, e.g., strategic planning. Many believed that the same planning process is applicable to all fields (e.g., institutional, community, and corporate planning). To be sure, the generics would have to be adapted to the specific situation of the health planner. For instance, when referring to community health planning, the generic planning process would include more specific areas such as methods for selecting those individuals truly representative of the community. Stated differently, the generic planning process provides a foundation upon which any type of specific structure (planning area of interest) can be built.

Experiential learning was mentioned as one way of adapting the generic process to the specific situation. For instance, the planning student could be assigned to an organization to conduct a project; or he or she could be part of a group of students--either all planning students, planning and administration students, or a multi-disciplinary group of students--assigned a field exercise. Of course, experiential learning can also provide a learning situation which addresses areas besides planning such as communication skills, small-group dynamics, and decision-making techniques.

In addition to the specific vs. generic planning process discussion, the conference addressed the question of whether specific planning tools or the logic behind these tools should be emphasized in the various planning courses. Many participants stressed the need for tools to be included in the curriculum. Such tools should not be merely the tools of health planners, if tools specific to health planning exist at all, but should be tools used by health planners, social planners, corporate planners and others.

It appears, however, that without necessarily labeling it as such, the participants dwelt considerably on the logic behind the tools and the environment in which the tools are used. For instance, it was stated that all

planners use the same tools, but this use and the results vary according to the specific situation in which the tools are used. The values associated with the use of specific tools were also discussed. Some expressed the belief that the tools themselves contained or supported various ethical, moral, and/or political values. Other participants believed that the values were situation-specific, and thus a given tool would contain different values in different situations. One method suggested to lessen this value problem was to address the equity implications of using the tools and to maintain a concern for individuals when using a specific tool.

Finally, specific courses, skills, tools, areas of interest, and disciplines were mentioned as being potential candidates for the community health planning curriculum. The importance of these areas ranged from "strongly needed" to "nice to have." Most of these specific courses were in addition to already-existing curriculum offerings, and thus would require careful evaluation before they were either added to the curriculum or (more likely) were substituted for existing courses. These specific areas included the following: community consensus-building, community power structures, local political processes, human resources/human relationships, technology development and assessment, communication skills, and public relations.

In summary, it appears that most participants agreed that health planning will undergo a thorough review in the next several years. The result of this review and redefinition will quite likely be a renewed emphasis at the community level. Health planning curricula, whether separate or part of larger health services administration curricula, will have to undergo a parallel review and redefinition. The result will likely be a continued multi-disciplinary approach to planning, including areas from corporate strategic planning to local area political analysis to health care technology assessment and development. Interest in community health planning and its results will likely broaden to include health care institution administrators and private-sector business executives. The possibility of a uniform or generic curriculum appears to be remote, and thus each school can continue to use its existing expertise to provide a creative, unique approach to community health planning.

# TEACHING PLANNING METHODS WITH A CONTINGENCY FRAMEWORK

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## Planning

Planning is activated when performance repeatedly falls below norms (Nutt, 1979; Cyert and March, 1963). Planning attempts to transform the undesirable state to a better one, using the norm as a goal to guide the effort (Backoff, 1976). The current problem state is defined by performance gaps, such as preventable infant mortality or declining hospital utilization. Norms specify an attainable mortality level, or target utilization level.

### Planning Methods Defined

Planning methods are tools used by planners. They have two distinguishing features: process and technique (Nutt, 1981). The typical planning method has several interrelated stages. Process spells out the sequence or order in which these stages are to be carried out. Technique is the approach used to deal with the issues raised in each stage of the process. A planning method can be fully defined in technique and process terms. For instance, the "Program Planning Method" (PPM) identifies five stages: problem exploration, knowledge exploration, priority development, program development, and program control and evaluation (Delbecq and Van de Ven, 1971). The "nominal group" is the technique used to identify problems in stage one and possible solutions in stage two.

### Problems with Application

A partial listing of planning methods appears in Table 1. A review of these planning methods reveals many differences in process. Their sequence of stages and steps within stages are markedly different. For example, PPM sets the stage for solution development, which is the last activity in the process. Only when the ramifications of several types of solutions to priority client problems have been explored and tacitly approved does solution development become relevant. Systems approaches, by way of contrast, stress solution development as a primary concern and treat implementation as external to the process.

Process diversity is typical, with some methods ignoring issues considered fundamental to others. For example, some planning methods consider problem definition as a given. Other planning methods regard implementation as a sponsor responsibility. Engineering-based methods (e.g., Asimov, 1962) often unfold sequentially, moving from problem definition to plan installation in a series of logical steps. The Delphi approach (Dalky, 1967) places great emphasis on search, providing few rules to synthesize or analyze the information gleaned from the survey. Thus, virtually every planning method proposes a distinct order (process) for planning activities to follow.

The dogmatic nature of some planning theorists, perhaps better described as popularizers, clouds the issue of method appropriateness. Once a method has been devised, its developer often feels an obligation to spread the word--help the "great unwashed" by showing them the "one best way." Examples abound. The "n step approach" of several well-known consulting firms and academics should come to mind. The exhortations of the popularizers, however, have had little effect outside captive planning practitioners, such as the employees of their consulting firm.

Studies suggest that a composite of several processes and techniques is typically used and that much planning is done informally (Witte, 1972; Nutt, 1981). The planning processes applied in practice are made up of techniques drawn from several sources. Prescriptive processes found in the literature are seldom applied. This may be due to gaps practitioners have found in these processes, where they fail to deal with a key issue like evaluation, or because skilled planners have become adept at synthesizing planning ideas.

Much of the observed planning activity is informal and unstructured (Nutt, 1981). For instance, rather than exploring the sponsor's definitions of need or opportunity these stipulations are taken as givens (constraints). In other cases, time pressure or limited budgets cause planners to adopt a truncated version of their usual repertoire. This may suggest that the planner sees these activities as lacking importance, or at least low-priority. Most theorists argue that planning results could be improved if formal techniques and a more comprehensive process were applied more often.

While planning is an important element in a manager's overall armament, little is known about which method is best for certain types of applications. This situation stems from the extreme difficulty of comparing planning methods by way of controlled experiments. Establishing comparison groups and controlling extraneous factors make research which compares planning hard to execute and likely to fail. To carry out planning a lengthy period of time is required. During this period many extraneous factors which are often impossible to control can influence the planning results. These factors include the waxing or waning of sponsor and/or planner interest, resources commitments, and priorities. Redundant comparison groups are often infeasible. Even when feasible, information leakage among the various planning groups is hard to prevent. Each planning group is just a single observation in such a study. As a result, large amounts of time and money are required to make valid comparisons about a single process variable.

In brief, there are few, if any, rules for method selection but many methods among which to choose. This makes the adoption of a particular planning method an act of faith. Further, in practice planning is often carried out without much in the way of structure--which cries out for more systematic approaches.

A technique synthesis fit to a generic process provides one way out of this dilemma. By dealing with planning at the technique level, research (while not plentiful) has been done and can be used to provide guides to selecting among techniques. Using available research findings, "techniques strings" will be fit to stages in a planning process. Hybrid planning methods are made up of technique strings across stages which seem likely to produce various combinations of quality, acceptance, and/or innovation in plan

results. To teach planning in the 1980s, such rules for technique selection will be essential. In the discussion which follows, the stages of the generic process are defined, along with techniques that fit each stage.

The Generic Planning Process

A generic planning process has stages common to most processes (Nutt, 1981). To specify process stages, a large number of planning methods were reviewed to identify stages common to each process. For instance, Le Britton and Henning (1961) identify stages which they term authorization, needs, objectives, plan outline, tentative solution data, evaluation, revision, approval, and the like. Nadler's (1970) stages include function determination, ideal system definition, information, alternatives, workable system, testing, installation, and performance measurement. Processes suggested by planning theorists were distilled until a parsimonious composite of stages emerged. Table 2 illustrates how these stages can be fit into a generic planning process.

For brevity, this paper will emphasize the creative activities in planning. Creativity tends to be concentrated in stages one, two, and three where problems and objectives are defined, models are constructed, and solution alternatives are developed. Each is a part of the creative act in planning. Evaluation (stage four) seeks information to select among alternatives and has quantitative and judgmental components. Implementation (stage five) involves garnering plan acceptance. Both are important, but emphasize activities less likely to lead to innovation in a solution.

I. The Formulation Stage

Formulation (stage one) clarifies the problem stipulation offered by a sponsor. Stage one has discovery, decision and structuring phases which can be activated. Technique strings for the formulation stage are defined by the techniques used to carry out these phases.

The Discovery Phase

- Silent Reflective Techniques - Reflective group techniques require a group of users to contemplate their problems prior to any discussion. In open discussion groups, premature interaction, member inhibitions, and hasty evaluations have been found to shut off valuable lines of inquiry--which reduces innovation and acceptance (Vroom et al., 1969; Bouchard and Hare, 1970; Nutt, 1978). Reflection overcomes barriers to candor and stimulates the creative processes in people (Nutt, 1977; Van de Ven and Delbecq, 1974). There are two group processes which qualify: the Nominal Group Technique (Delbecq and Van de Ven, 1971) and Brainwriting (Gueschka et al., 1974).

  The Nominal Group Technique, or NGT, in stage one uses four steps: silent recording of problems; listing, with each member providing a problem from his or her list one at time until all the lists are exhausted; discussing the problems to consolidate these lists and to share information about the importance of each problem; and selecting priority problems to focus planning. Brainwriting starts with a preliminary list of problems being placed in the center of the table. Group members take a

sheet and add a problem or two, return their lists, and continue until all their problems are exhausted. The discussion and listing steps of NGT can be used to create priorities.

- Survey - A survey process tests the sentiments in important reference groups, pooling judgements without discussion. A synthetic group is created by pooling responses. A traditional survey provides a barometer of opinion, when respondents are selected by a random sample, and a reference point for discussion, when the group has carefully selected expertise. A Dephi survey (Dalky, 1967) systematically selects and collates judgments to form a synthetic group. A series of questionnaires are used. In the first, information, ideas, opinions, or viewpoints are solicited along with the rationale which supports the information, ideas, etc. Subsequent questionnaires consolidate the problems and encourage feedback so each member can review the views and rationale of the others. In the final survey, members prioritize.

- Interacting Groups - Free-wheeling discussion groups are often used to define planning problems for stage one. An interacting group has a conventional face-to-face format and discussion is free-flowing and open-ended. It uses little in the way of process, relying on an agenda and the leader to retain an issue focus. These groups can be dyadic, as in the case of a sponsor and a planner discussing symptoms and groping for a problem definition (Boland, 1978).

The Decision Phase

In the decision phase, problems are sorted into groups in terms of their priority. The decision mode describe how the planner organizes the decision process.

- The Decision Mode - Two modes can be used: Estimate-discuss-estimate (EDE) and Q-sort. EDE (Gustafson et al., 1971) recognizes that most groups want time to reflect and regard all choices as preliminary, subject to change pending more information. A reconsideration phase helps to reduce uncertainty (Huber and Delbecq, 1972). EDE has three steps: independent preferences, discussion of initial consensus, and final vote. The independent preference step has each member give their initial preference, making it independent of any pressure to conform. Group averages, depicting for instance average ranks, are used to stimulate discussion. This keeps the discussion impersonal. Members must argue why a given problem is ranked too high or too low, not why a given member's view is wrong. This allows the persuasiveness of the argument to dictate need for change in the rankings. A final vote is taken after each problem is discussed.

  The Q-Sort procedure helps a decision-maker prioritize large (more than sixty) numbers of problems (Kerlinger, 1967; Stephenson, 1953). When faced with such a task the information-processing demands can make any ranking process, particularly those in a survey, unreliable. The Q-sort procedure has the decision-maker first look for the most important problems and then the least important ones, switching back and forth until all have been categorized. The number of items in each pair is equal and follows the approximate shape of a normal distribution.

- The Ranking Step - In each decision mode, methods of ranking are used to establish an index of merit or to combine indices based on several criteria. They include: anchored rating scales or ARS (Nutt, 1980); paired comparisons; rank-weight (Huber, 1974); direct assignment (Gustafson et al., 1971); and pooled rank (Delbecq et al., 1975) techniques.

The Structuring Phase

This phase offers the planner a way to organize the priority problems into a statement of direction for the planning effort. Two structuring techniques are described: Function Expansion (Nadler, 1970) and Stakeholder Analysis (Mitroff et al., 1979; Emshoff, 1980).

- Function Expansion identifies an objective for the planning process. The technique uses an expert group that inspects the priority problems and identifies possible objectives. The leader helps the group arrange these objectives in a hierarchy so each objective encompasses all those below it in the hierarchy. One of the decision modes and ranking techniques is used to select the most appropriate objective.

- Stakeholder Analysis identifies and examines assumptions which lie behind a performance gap. The technique can begin by considering problems identified in the discovery phase or those stipulated by a sponsor. The technique seeks to reconcile key stakeholders' beliefs about solution concepts which can overcome these problems. The Stakeholder technique identifies assumptions upon which the plan is based, critiques each assumption, produces alternative assumptions, and selects an assumptional set to guide planning. The steps are: identification of the stakeholders, group formation, assumption surfacing, within-group dialectic, and among-group dialectic. Many of the group process options have application in each structuring technique, as do the decision modes and ranking techniques.

Technique Strings for the Formulation Stage

Technique strings, useful in the formulation stage, are summarized in Table 3. Each string is made up of a particular set of techniques for the discovery, structure, and decision phases. The discovery phase can be carried out using various group process options including silent reflective processes (such as NGT), survey (such as Delphi), and interactive approaches. The two structuring processes were Function Expansion and Stakeholder Analysis. It should be recalled that the group process options can be used to aid in either the discovery or the structuring phases. The decision processes are defined by their mode and their ranking approach. Two modes were identified: EDE and Q-sort. The ranking techniques discussed were ARS, paired comparisons, rank-weight, direct assignment, and pooled rank. A decision process is used to terminate both the dicovery and the structuring phases. In all, there are 120 technique strings defined by Table 3. Some are infeasible but others offer a new synthesis of techniques which can be used to approach formulation.

II. The Conceptualization Stage

In stage two, an idealization is created to demonstrate feasible options.

The idealization, or model, points out distinctive ways to deal with the planning problem and meet process objectives. Model building has two phases. First, creativity-inducing techniques are used and then structure is imposed. Creativity techniques permit the planner to open up model building before the imposition of structure. In the second phase, techniques which can be termed holistic or reductionist are applied to create a representation of solution options.

Creativity Techniques

Creativity techniques can be classified as process-based or as free-association. Useful process-based techniques include Delphi, NGT, and Brainstorming, which are applied to enumerate solution ideas in stage two. Free association techniques include Synectics and Lateral Thinking.

- Synectics - The Synectics process was devised by Gordon to induce creativity in groups (Gordon, 1971). To enhance problem comprehension, a metaphor or an analogy is used to get the group to take an excursion (a creative trip) intended to bring home a new perspective. The process involves stating the problem (obtained from stage one), purge (listing preconceived solutions), excursion (considering direct, personal, and symbolic analogies to visualize solutions), force-fit (connecting the analogy to the problem), and viewpoint (shaping the idea to make it feasible).

- Lateral Thinking - De Bono proposes lateral or sideways movement to create new patterns of thought (de Bono, 1970 and 1972). Lateral thinking can be used by, but is not restricted to, groups. There are four steps that are usually applied: new pattern creation, old pattern challenge, provocative information merger, and pattern disruption. New patterns are created by substituting the word "Po" for all connectives, such as "no," in the discussion. Po can also be used to create new patterns which challenge traditional arrangements and disruption patterns to serve as the basis for a new merger of ideas.

Structuring With Holistic Strategies

- Scenarios - The writing of scenarios grew out of the need to visualize alternative futures as a "housing" for a plan. The scenario provides a contingency framework which specifies a variety of political-technological situations in which the plan must function and plan features. The principal ingredients in scenario writing, according to Quade and Boucher (1968) are contruction (identifying factors by linking probable causal events), theme selection (how environment is defined), factor-theme merger (selecting most likely combinations), and definition of various types of events (e.g., most likely, best-worst situation, etc.)

- Morphology - Zwicky (1968) devised morphology to create many diverse options for a planner to ponder. In morphology, a solution option is defined by all possible combinations of elements of its key components. For example, key components in a community health plan could be the care needed, its urgency, and the like. Elements for each component could be privately-insured or indigent to define patients; acute, chronic, rehabilitative, custodial care to specify the care component; and the

care's urgency in terms of convenient, urgent, or emergent. All combinations of the elements create plan options.

Structuring With Reductionist Strategies

- Tree Structures - A tree structure has a recognizable hierarchy and subdivisions of each level of the hierarchy. Four types can be identified: Objective Trees, Activity Trees, Decision Trees, and Relevance Trees. The vertices are specified by objectives in an Objective Tree, by activities in an Activity Tree, and by choices in a Decision Tree. Each has applications in other process stages. The Relevance Tree has different types of vertices at each level in the hierarchy. Connections stem from the relevance one set of items has for another. Broad issues fall at the top of the hierarchy and narrow ones at the bottom, with the tree terminating in a list of specific actions. Relevance Trees are specified by network techniques (see, for example, Warfield, 1976).

- Input - Output - The inputs, transforms, and outputs in an existing system provide a structure to model a solution (e.g., Hall, 1962). The model is made up of inputs and outputs from an operating system (or a synthesis of systems) that are strung together. A "black box" strategy is used where transforms (the means of converting inputs to outputs) are ignored. The model is then pruned and enriched to ensure consistency (Morris, 1967).

Technique Strings for the Conceptualization Stage

Table 4 defines technique strings which can be used for the conceptualization stage. Each technique string for stage two has a creativity phase and a structuring phase. The creativity techniques fall into free association and group-process categories. The structuring phase can be done by using holistic or reductionist techniques. All combinations of the six techniques in the creativity phase and the four in the structuring phase identify 24 technique strings for stage two.

III. The Detailing Stage

In stage three, several solutions are detailed to extract the policy implications from each. The detailing stage has two phases which can be activated: constructive and interrogative. The constructive phase is used to describe the operating characteristics of each system solution and the interrogative phase provides a means to test it. The interrogative phase often requires a structuring and a path-defining component. A particular technique string for the detailing stage is defined by the techniques selected to carry out the constructive and interrogative phases.

The Constructive Phase

The constructive phase details the solution, using the model from stage two as a guide. There are three types of detailing techniques: systems approaches (e.g., Nadler, 1970); General Systems Theory (e.g., Klir, 1969; Weinberg, 1975; and Cavallo, 1979); and current system models (e.g., Wilson and Wilson, 1975; Quade and Boucher, 1968).

- Nadler's Systems Matrix technique has two unique features: its systems definition (a matrix of seven elements and four dimensions) and its procedure to detail the system. To fully define a system, each element and dimension in the matrix must be defined. A six-step procedure is used, beginning with attempts to eliminate the system's objective and thereby the need to plan the system. This step is followed by finding system regularities, listing system features, elaborating each system feature, dividing systems into feasible and ultimate, and detailing the target system. Both group-process options and creativity techniques can be used at several points in the process.

- General Systems Theory offers a generic description of system features. For example, Klir's approach defines system traits, rather than system axioms. The traits define behaviors, states, transitions, elements, couplings, levels of resolution, and the link between transitions, which are described deterministically and stochastically. The traits are classified to provide five system definitions. By enumerating the traits of the system to be planned, as described in stage two, an approximate system definition can be selected to use as the basis for planning.

- Current system models (also called system analysis) describe how a reference system operates. The system model traces the transforms needed to connect all inputs to outputs. The model can be enriched by synthesizing the best aspects of several current systems.

The Interrogative Phase

Most interrogative techniques treat the system solution as a 'glass box' showing how inputs are to be converted to outputs. The transformation process is modeled so refinements can be made to fine-tune the solution. Two types can be used: Interpretative Structural Modeling or ISM (Warfield, 1976) and Operations Research.

- ISM is based on graph theory. Its procedure helps the planner sort out steps in the system's transformation process. It has particular value in formalizing the implicit procedures used by people when seeking to automate these procedures.

- Operations Research techniques (e.g., Simulation, Queuing, and Mathematical Programming) are termed interrogative, because they require an operating system to model, making them reactive rather than proactive planning tools. To refine the transformation process PERT or CPM techniques can be used to find the optimal (or constraining) pathway. Delta Charts (Warfield, 1973) add feedback steps, decision points, control functions, and logic to the process steps (or events) in a PERT network.

Technique Strings for the Detailing Stage

Table 5 defines technique strings which can be applied to detail the plan. Each string for stage three has a technique drawn from the constructive and the interrogative phase. The interrogation may require a path analysis as well as a structural test. All combinations of the three constructive and four interrogative techniques define 12 unique technique strings.

## Constructing Hybrid Planning Methods

The basis for selecting a particular technique string will be derived from the results that each technique has been found to produce, or, in the absence of research, from logical analysis. A synthesis of research findings and logic will be used to provide a basis to sort out the merits of particular techniques. A hybrid planning method is made up of a technique string defined by grouping techniques which deal with the discovery, structure, and decision phases in stage one; the creativity and structuring phases in stage two; and the constructive and interrogative phases in stage three.

### Criteria

The desired results of planning serve as the basis for selecting a technique for each stage of a planning process. Three generic criteria have been used in research studies: solution quality, acceptance, and innovation (Nutt, 1976). Quality measures the technical excellence or internal integrity of a solution, usually in cost-benefit terms. A high-quality solution is often close to the state of the art for the plan's subject matter. Acceptance deals with the subjective views of those affected by the plan, particularly people that can block implementation. Without acceptance, plans can be blocked or covertly subverted. To be innovative, a plan must be based on ideas not previously recognized or attempted. Organizations seek originality in their plans hoping that a few will prove to offer a decisive advantage.

### Guides to Select Techniques

Tables 6, 7, and 8 provide decision trees to aid in selecting a technique string for each stage, depending on the demands for quality, acceptance, and innovation. By tracing the demands for each of the criteria by the plan, an ideal technique string can be selected that spans the formulation, conceptualization, and detailing stages. In all, there are eight paths in each decision tree, which will be used to identify 13 hybrid methods ideal for projects that require quality, acceptance, and innovation or that make less stringent demands.

### Path 1: Comprehensive Planning

Stage One: The first path makes the most stringent demands requiring quality, acceptance, and innovation, called "comprehensive" planning. As shown in Table 6, when all these outcomes are required, a silent reflective group process is coupled with Stakeholder Analysis. The interactive discussion used to identify clients, preferred solutions and assumptions during the Stakeholder process is replaced by NGT group process. NGT was found to stimulate innovation (Van de Ven et al., 1974) and acceptance (Van de Ven et al., 1974; Nutt, 1977). The Stakeholder method is preferred because it provides an elaborate structuring, which may be needed for planning problems which demand quality and innovation coupled with acceptance. The decision process takes on less importance because group process and structuring techniques have formal procedures built into the approach. To speed the voting, EDE with a comparatively fast ranking process, like pooled rank, is recommended.

Stage Two: Path 1A defines comprehensive projects that have considerable uncertainty (Table 7). Scenarios help to clear away the uncertainty. Each Scenario can be further structured using Morphology or a Relevance Tree to create a structure for the issues defined in the Scenario. NGT was selected to manage the creativity phase for two reasons. First, NGT can clear away uncertainty and identify priority factors for Scenarios to consider. Second, NGT stimulates acceptance and has been shown to be innovative (Nutt, 1977). Delphi can be substituted for NGT if logistics make meetings difficult.

Path 1B defines comprehensive projects where uncertainty is low. The recommended technique string merges Synectics with Morphology. Morphology gives a quick, concrete representation of the problem. Scenarios seem unnecessary when planning is to be done in a known environment; however, known environments tend to cause a fixation on what is, which lowers creativity. A Synectics exercise is used to identify Morphology factors that are creative. Synectics is recommended because it seems better matched to the Morphology technique than does Lateral Thinking. Technique selection, however, should depend on the planning group's familiarity with it and their acceptance of it. If neither is acceptable (a possibility due to their unusual approach), NGT can be used.

Stage Three: In stage three, there is virtually no comparative research so selection must depend on logical analysis with all of its potential pitfalls. For comprehensive projects (demanding innovation, quality, and acceptance) in the detailing stage, the Systems Matrix approach is recommended along with ISM, Operations Research, and Delta charts (Table 8). This technique string seems best because only the Systems Matrix technique strives for innovation and can build in acceptance through participation. ISM complements the Systems Matrix approach and tests the viability of the transforms. Operations Research models may be needed to refine the solution, to add to its quality.

Path 2: Traditional Planning

Stage One: Projects which do not demand innovation are identified by Path 2. Such projects are called "traditional" because most planning efforts do not stress, or seek, innovation (Cyert and March, 1963). As shown in Table 6, there are two techniques that can be used, depending on the time available. Path 2A assumes that rapid completion is demanded. For traditional fast-closure projects a silent reflective group process is added to the Function Expansion to stimulate acceptance. Function Expansion has been found to provide quality results but does not influence acceptance (Nutt, 1976; Nutt, 1977). Using an NGT or a Brainwriting session to identify objectives in the hierarchy retains the synthetic benefits of Function Expansion but manages the group efforts better. Function Expansion does not innovate (Nutt, 1977), but in Path 2A innovation is not essential. An EDE decision mode seems best because it creates a rapid consensus (Gustafson et al., 1971). Paired comparisons are recommended to select the objective because this method reduces the information-processing demands and yields precise results. There are seldom more than ten objectives identified. Typically, some can be ruled out, creating 30 or fewer comparisons which is a manageable number. The ranks of each member can be averaged to give a preliminary decision on the

best objective. The EDE decision mode focuses the discussion on the merits of the preliminary selection. Final voting is also done by paired comparison.

Traditional projects that lack time pressure (Path 2B) can profitably use Delphi. Delphi survey techniques have been found to produce quality and acceptable plans (Boone-Young, 1976); however, Delphi is seldom timely. Between six weeks and two months are needed to complete a Delphi survey. Delphi has several benefits which can be exploited if the planner has the time to apply it. First, Delphi creates a wider range of information because it can tap a wider array of expertise. Second, Delphi costs less than NGT (Delbecq et al., 1975). When time permits, Delphi is an excellent way to formulate a traditional planning problem particularly when a Q-sort is used by the Delphi panelists to prioritize. The Q-sort enables panelists to structure their choices in an unambiguous manner, overcoming a major failing of the Delphi approach. The prioritization process must stress two criteria in Path 2B--quality and acceptance--so two sorts are needed. As a final step, the panelists weight the criteria. In this type of application, the ARS voting technique is best (Nutt, 1980). The planner combines the Q-sort using normalized values drawn from the ARS scale.

Stage Two: A Relevance Tree, coupled with either NGT or Brainwriting, is a workable technique string for traditional projects (Table 7). The group process creates acceptance (Nutt, 1979; Van de Ven, 1975), while defining the priority elements to be included in the tree. Several NGT's, one to identify levels in the Relevance Tree and others to elaborate several levels, may be needed.

Stage Three: For a traditional project, either the Systems Matrix or the Block Diagram approach can be used (Table 8). Quality in the solution can be enhanced by one of several Operations Research techniques. Delta charts may be needed to capture the logic tests demanded for projects devised by Path Two.

Path 3: Ideal Prototype Planning

Stage One: In Path 3 quality and innovation are stressed. The "ideal prototype" creates a benchmark against which other plans can be gauged. It is similar to the architect's first rendering or the automotive designer's mock-up. As shown in Table 6, the preferred technique string to formulate an ideal prototype combines a Delphi survey with Stakeholder Analysis. Because acceptance is less of an issue, a Delphi survey is used to tap reference groups that have relevant knowledge. The survey places less emphasis on internal (e.g., organizational) groups, unless they are thought to have relevant information. The Stakeholder approach is preferred because it is designed to produce innovation or a new view of the problem (Mitroff and Kilmann, 1980). Traditional interactive devices are used. The Stakeholder approach can be implemented as proposed, with one exception: the dialectical phase is skipped. This permits planners to focus on the problematic planning region in an attempt to discover new stakeholders and their implications.

Stage Two: For ideal prototype projects, free-association creativity technique should be used during conceptualization (Table 7). Lateral Thinking may be marginally better because it offers the widest possible latitude of inquiry. The structuring phase can be done with Scenarios because of the high uncertainty in Path 3A. Path 3B, with low uncertainty, calls for Morphology.

Stage Three: Path 3 demands quality and innovation. Current system models are unwise for the ideal prototype project because they use arrangements that lack innovative elements as a template. Either the GSM or the Systems Matrix approach can be used because the acceptance produced by the latter approach is not essential for ideal prototype projects. ISM is preferred to ensure that the mechanisms which transform input to output are logically constructed. The PERT approach is used if a schedule of implementation tasks is needed to test the solution's feasibility.

Path 4: Utility Planning

Stage One: Neither innovation nor acceptance is important in Path 4. "Utility" planning describes those projects that merely close the performance gap. The traditional form of Function Expansion, with an interacting group process, can be used. This approach seems ideal because the structure provided by Function Expansion, and an implicit interacting group, was found to offer quality, modest levels of acceptance, and little innovation (Nutt, 1976). An interactive group process is preferred because it is faster than using NGT. The decisional phase should force a careful consideration of each objective, calling for an EDE decision mode and paired comparisons. The Q-sort is unnecessary because the number of objectives to be compared is seldom more than ten. The paired comparison requires the group members to contrast each objective in terms of its potential to produce quality.

Stage Two: Conceptualization for utility planning just stresses quality. Table 7 shows that the creativity phase is skipped because neither acceptance nor innovation is needed. Input-output models should be used because they stress an exhaustive representation of the malfunctioning system. Because innovation is not necessary, tracing important relationships in an existing system is quick and should provide an accurate representation of the problem. Quality is enhanced if the synergistic elements of the system are preserved in the model and because the model focuses on details.

Stage Three: The Block Diagram approach (which provides a current system model) coupled with Operations Research techniques should be adequate for utility projects. If a schedule of the implementation steps is needed, PERT can be used.

Path 5: Awareness Planning

Stage One: "Awareness" planning is undertaken to influence the acceptance of innovation. Because quality is unimportant, the structuring phase in the formulation stage can be skipped, which reduces planning cost. As shown in Table 6, any silent reflective group process can be used (Nutt, 1976; Nutt, 1977). Structure is added by prioritizing the large number of

planning problems which stem from an NGT or Brainwriting session. The EDE decision mode is recommended with a pooled rank voting approach (Delbecq et al., 1975), but this decision process forces group members into a difficult information process task. Combining the Q-sort with the EDE process aids a NGT or Brainwriting group by reducing these demands to manageable proportions. As in Path 2B, two Q-sorts are required: one for acceptance and one for innovation. These criteria are weighted by the ARS approach. The criteria weights are normalized, converted to percents and multiplied by each list stemming from Q-sort ranks. The values for this list are added by item to combine the lists. The debate focuses on the merged rankings from a Q-sort. After discussion, the Q-sort is used again and the final ranks are computed in the same manner as described above.

Stage Two: Group process is an important aid to stimulate creativity for awareness planning projects, in which both acceptance and innovation are required. For these projects, shown in Table 7, either NGT or Brainwriting can be used, without the structuring phase, which is deleted to speed the process. In Path 5B, where innovation is not just needed, but critical, a combination of NGT and Synectics can be used. In the Synectics process, NGT is used in place of group discussion.

Stage Three: Detailing in an awareness project calls for the Systems Matrix approach. This technique seems best because innovation can be stimulated and because its group process improves the prospect of acceptance. Separate NGT groups, one with clients and the other with experts, can generate ideas and merge them (Nutt, 1976). Conflicting ideas create the potential for conflict and must be handled carefully by the planner. Interrogative techniques are not needed because quality is not essential. The detailed plan is valuable because it shows a new way and paves the way toward acceptance of change, not because it offers an airtight solution to the planning problem.

Path 6: Seduction Planning

Stage One: In Path 6, only acceptance is needed. Such a project is called "seductive" because it merely tries to gain acceptance for a predetermined plan. Little in the way of structure is needed. Research shows that NGT creates more solution acceptance in the formulation stage than interacting groups, so NGT is preferred (Table 6). The sponsor must have "plants" in the group who will offer problems consistent with the sponsor's pet idea. The EDE (Gustafson et al., 1971) decision mode is preferred because it can be managed to give the appearance that members were reflective, suggesting that each problem has been completely appraised. The pooled voting technique is the easiest to understand and thus the most likely technique to gain the group's acceptance.

Stage Two: A seductive project can use any of several group process approaches to aid in conceptualization. As shown in Table 7, NGT or Brainstorminig can be used, but since NGT is better at creating acceptance it is generally preferred (Nutt, 1976; Van de Ven, 1975).

Stage Three: Planning with seductive motivations does not require careful detailing. An adaptation of the Systems Matrix approach is recommended. A modified version of NGT is used, with users of the system rather than

experts asked to define the system. The System Matrix aids client participants by guiding them through the steps required for detailed planning as a cooptative device.

Path 7: Idea Planning

Stage One: Path 7 stresses innovation so it is called "idea" planning. Group processes which stress acceptance can be dropped when they seem excessively costly for stage one; however, as shown in Table 6, silent reflective techniques are superior to other group processes in producing both innovation and acceptance. The idea planning prescription in Path 7A mirrors that of Path 6 (in stage one) when time is short. Any silent reflective group process, coupled with EDE and pooled rank, should work under these circumstances.

When time constraints are less severe, Delphi coupled with a Q-sort can be used for idea planning, as shown in Path 7B. This technique string will create a large and well-prioritized information pool, using innovation as the sole criterion. Using a broad group of experts, the identification of innovation takes more credence than the local experts that are often used in a NGT.

Stage Two: For idea projects a free-association technique is recommended for the conceptualization stage (Table 7). Lateral Thinking can be used for a small group and Synectics can be used if the planning group is somewhat larger. Path 7A assumes that the planning team is made up of co-workers who can work at de Bono's process at some length. Path 7B is used when a consortium planning team must be assembled.

Stage Three: Only the Systems Matrix approach creates an environment in which innovation is possible in stage three. NGT with experts is used to provide the system's definitions. This improves the prospect that fresh and pertinent ideas will be created for each cell in the Systems Matrix. Because quality and acceptance are not needed for this type of project, interrogative techniques merely add to planning costs and are not required.

Path 8: Gesture Planning

Stage One: In Path 8 a planning process is initiated which makes no demands so it is termed "gesture" planning. If neither quality, acceptance, nor innovation are important, questions can be raised about the need for planning. Any project initiated under these conditions will be a posture (Nutt, 1981), carried out to create the trappings of objectivity to impress third parties. Sponsors may be acting rationally in creating such a planning effort when higher-ups initiate planning to show that "something is being done" in the hopes of placating critics. The planner accepts the sponsor's stipulations to define the problem. No formal technique is used because none would be helpful (Table 6).

Stage Two: When a gesture process is not aborted in stage one, planning can be a smoke screen, intended to disguise or to deflect attention used to sanctify someone's pet idea. Under these conditions, a current system analysis or historical model can be used. The former is used when the system is in place an is to be re-planned, and the latter is used when the system proposed does not currently exist (Table 7).

Stage Three: The Block Diagram approach is recommended for gesture planning. A current system analysis (or analysis of the pet idea) is all that can be justified. In most cases a description of the current system lets the sponsor demonstrate that planning is being attempted. Such an impression may be essential because gesture planning processes demand the appearance of planning, if not planning results.

## The Hybrid Planning Method Defined

Hybrid planning methods are made up of technique strings drawn from each path. A summary of the techniques that were recommended for each project type make up 13 distinct hybrid planning methods. They are summarized in Table 9.

## Summary and Conclusions

This paper defined hybrid planning methods in terms of technique strings that can be used to carry out the creative stages of planning: formulation, conceptualization, and detailing. First, technique strings for each stage were created. Six options for discovery, two ways to structure, two decision modes, and five voting techniques were used to define 120 hybrid techniques useful in formulating planning problems. In stage two, technique strings were created by combining the creativity and structuring phases of model building. Six ways to enhance creativity and four options to structure provided 24 techniques for model development. For detailing, constructive and interrogative techniques identified 12 technique strings for the detailing stage. Particularly useful hybrid planning methods were defined by decision rules to select the most appropriate technique strings. These technique strings were merged to form hybrid planning methods.

Table 1

A COMPARISON OF PLANNING METHODS

| Origin | Engineering-Based Methods | | | |
|---|---|---|---|---|
| Originator | Asimow (1962) | Woodson (1966) | Hall (1962) | Ediel (1967) |
| Summary of design processed | Planning Functions<br>-Feasibility<br>-Preliminary design<br>-Detailed design<br>-Production plan<br>-Distribution plan<br>-Consumption plan<br>-Retirement plan<br><br>Design Functions (at each planning level)<br>-Analysis<br>-Synthesis<br>-Evaluation<br>-Decision<br>-Optimization<br>-Revision<br>-Implementation | Feasibility Study<br>-Validate need<br>-List problems<br><br>Preliminary Design<br>-ID parameters<br>-Optimize<br><br>Detailed Design<br>-Performance specifications<br>-Solution description<br><br>Revision<br>-Test and modify<br>-Implement | Program Planning<br>-Which project<br>-State of art assessment<br>Problem Definition<br>-Gross need definition<br>-Crude input-output (I/O)<br>Select Objectives<br>-Performance criteria<br>-Synthesis of possible I/O<br>Systems Synthesis<br>-Evaluate alternatives re: objective function<br>-Test logic<br>Systems Analysis<br>(cost & quality trade-offs)<br>Optimize<br>(sort out nonfeasible alternatives)<br>(Repeat first 6 steps and increase detail each iteration)<br>Determine operating conditions<br>Engineering (field trials, production, etc.)<br>Market Acceptance | Initiation<br>-Stimuli identified<br>-Goals/objective<br><br>Exploration<br>-Information<br>-Prob explanation<br>-Systems definition<br><br>Concept Formation<br>-Models & economics<br><br>Preliminary Design and Development<br>-Aesthetics<br>-Human factors<br>-Drawings<br><br>Detailed Design for Production<br>-Production engineering<br>-Optimize<br><br>Modification and Implementation |

Table 1 (Continued)

| Origin | Engineering-Based Methods (Cont.) | | System-Based Methods | |
|---|---|---|---|---|
| Originator | Wilson (1965 | Krick (1965) | McCrory (1966) (in Gregory) | Watts (1966) (in Gregory) |
| Summary of design processes | -Statement of needs and objectives<br>-Feasibility and preliminary design<br>-Development<br>-Prototype construction and evaluation<br>-Final design<br>-Field test and oberva-tion | Formulation<br>-imput/output problem definition<br>-Redefine<br>Problem Analysis<br>-Input & output to identify variables & constraints<br>-Solutions posed by variables & restrictions<br>-Criteria<br>-Volume & usage estimates<br>Solution Search<br>(check lists)<br>-Maintenance<br>-Creativity<br>-Diversity of solutions<br>-Reduce randomness<br>Choice<br>-Measures of effectiveness<br>-Effect predictions<br>-Compare solution attributes<br>-Select<br>Specifications<br>-Physical attributes documented<br>-Decision to redesign<br>-Acceptance<br>-Installation<br>-Initial use analysis<br>-Surveillance & use evaluation | Design Process<br>-Identity State of Art Re: Need<br>-Inputs; social needs & state of art, balanced to have justifiable design<br>Synthesis; needs & capability to meet needs matched<br>Design Concept<br>-Iterate through solution possibilities<br>-Choice<br>-Speculate<br>-Manipulate analytic description<br>Design Feasibility<br>-Concept performance<br>-Alternatives to satisfy each function<br>-Trade off alternatives<br>-Test<br>-Build prototype<br>Production and Market<br>-Specify performance criteria<br>-Detail design<br>-Technical & market acceptance measurements<br><br>(Design interfaces with marketing & R&D are described in 3 parallel processes) | Analysis<br>-Need definition<br>-Morphological breakdown of need components<br>-Trace function, input/output, interfaces<br><br>Synthesis<br>-Alternative way to perform each function<br>-Evaluate capabilities of components elements subsystems and systems<br>-Compare I/O<br>-Check compatibility and requirements<br><br>Evaluation<br>-Which I/O mix optimum<br><br>Repeat--more detail<br><br>(Continue to iterate until concrete and complete design emerges) |

Table 1 (Continued)

| Origin | Engineering-Based Methods (Cont.) | | Systems-Engineering Based Methods | |
|---|---|---|---|---|
| Originator | Roe et al (in Wilson) | Archer (1969) | Nadler (1970) | Jones (1963) |
| Summary of design processes | Problem Identification<br>.Defect recognition<br>.Need formulation<br>.Definition of design problem<br>.Design criteria<br><br>Search<br>.Alternative solutions generated<br><br>Evaluation<br>.Feasibility<br>.Optimization<br>.Selection<br><br>Implementation<br>.Communication and implementation<br>.Detailed design<br>.Defect rectified*<br>.Check on working solution<br><br>*If not, go back to start and repeat | Analytic Phase<br>-Programming<br>-Data collection<br>.Observation<br>.Measurement<br>.Inductive reasoning<br>Creative Phase<br>-Analysis<br>-Synthesis<br>.Evaluation .Judgement<br>.Reasoning .Decision<br>Executive Phase<br>-Communicative<br>.Descriptive .Translation<br>.Transmission<br>Given set of objectives, weightings, resources, use the following design process:<br>.Identify performance laws, i.e. ways performance laws affect goals<br>.Identify constraints on design variables<br>.Establish prevailing environmental states<br>.Postulate states for each design variable<br>.Determine solutions satisfactory with client<br>.Calculate index of matrix<br>.Select best alternative | Process:<br>-Function determination (substeps)<br>-Definition of ideal systems<br>-Information<br>-Alternatives<br>-Select workable from ultimate<br>-Formulate details<br>-Review<br>-Test<br>-Install<br>-Peformance (generate norms and controls for management strategy)<br><br>Processes used to detail a system defined as elements:<br>Functions<br>Output<br>Sequence<br>Input<br>Environment<br>Human agent<br>Physical catalysts<br>Each with dimensions:<br>Physical Control<br>Rate State<br><br>(To define a systems matrix, iterate through process, elaborating the matrix as necessary). | Analysis<br>.Random list of factors<br>.Classify factors<br>.Information sources<br>.Identify factor interactions<br>.Performance specifications<br>.Agreement<br><br>Synthesis<br>.Creativity<br>.Partial selection<br>.Limits<br>.Combined solution<br>.Solution plotting<br><br>Evaluation<br>.Methods for use--operation, manufacturing sales |

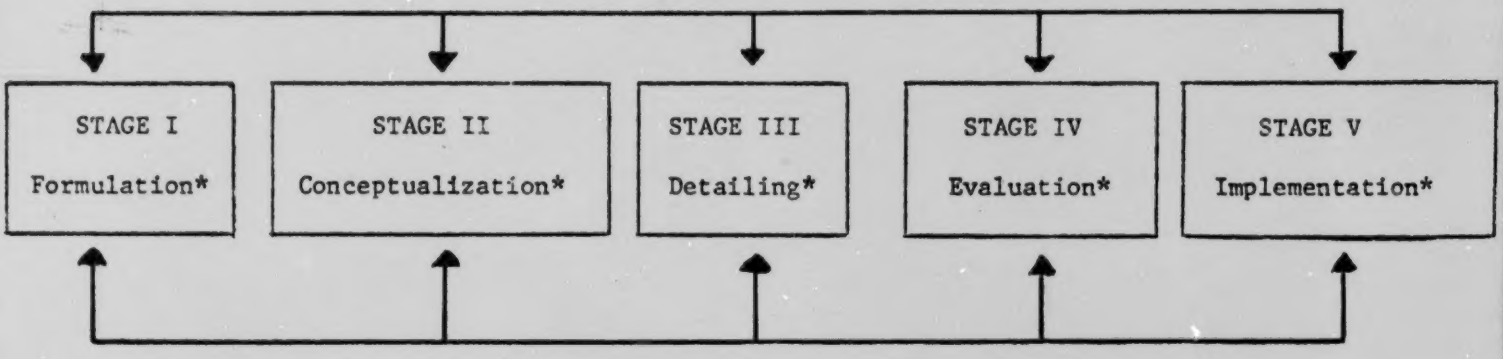
Table 1 (Continued)

| Origin | Systems-Based Methods (Cont.) | | | Planning-Based Methods | |
|---|---|---|---|---|---|
| Originator | Systems Command Manuals (adapted by McDonald, 1969) | Simon (1969) | Churchman (1968) | LeBreton & Henning (1961) | Delbecq (1971) |
| Summary of design processes | Mission statement<br>.Problem recognition<br>.Initiation of planning<br>.Approval<br>Concept<br>.Basic: goals, criteria<br>.Feasible: constraint, state of a components system description<br>.Prelim developmental plan<br>.Feasible system, gross req., resource needs, plan mgt system approval<br>Defin. phase (each subsys.)<br>.Analyze alt. solutions<br>.Operation req., interfaces<br>.Measure of effectiveness<br>.Select objectives<br>.Integrate<br>.Spec: system<br>Integrate subsystems—Test<br>Acquisition Phase<br>.Procure<br>.Detail design<br>.Monitor, test, start, train<br>.Procedures<br>.Installation plan<br>.Operational plan<br>Operation<br>.Aid in operation<br>.User eval. req. modif., site mgt.<br>.Acceptance, evaluation | (Inferred by author)<br>Problem Mileau<br>.Environment (fixed-variable goals and arena)<br>.Sanctions<br>.Search resources<br>.Partition solution space into acceptable states<br>.Aspiration criteria<br>.Stopping rules<br>Prob. Representation<br>.Factoring & decomposition rules*<br>."Laws of hierarchies"<br>.Design of components<br>Evaluation<br>.Satisficing, optimizing, level of aspiration<br>.Utility & criteria<br>.Resolution of conflict procedures<br>Implementation<br>(no discussion)<br><br>*Partition where interdependences expected to be minimal | Justifications<br><br>Plan System<br>I/O Components*<br><br>Identifications of the Decision Maker<br>.Criteria<br>.Rules of thumb<br><br>Organizational Design Group<br><br>Planning<br>.1st stage goal<br>.2nd stage goal<br>.Ult obj. crit.<br>.Est. optimum<br><br>Test<br>.Simulate comp.<br>.Counter plan<br>.Control<br><br>*Like Simon's concept | Steps<br>.Needs<br>.Objectives<br>.Outline plan<br>.Authorization<br>.Organ. staff Spec plan liaison<br>.Data obtain<br>.Eval. data<br>.Tentative solution<br>.Test solution<br>.Revise<br>.Test final plan<br>.Approval<br>Perform each step using theories of need determination, choice, data & testing<br><br>Checklist for each step complex, comprehension, time, specificity, completeness, flexibility, frequency, conf. nature, authorization, control, & implementation | Problem Exploration<br>.Nominal group methodology (NGM)<br>.Competent clients<br>.Identify critical problems<br>Knowledge Exploration<br>.NGM<br>.Diverse experts<br>.Identify solution requirements & resource (new, old)<br>Priority<br>.Presentation<br>.Identify acceptable solutions & needed compromises<br>Program Development (any method)<br>Control & Eval.<br>.Recheck solution validity<br>.Test acceptability |

TABLE 2

A NORMATIVE MODEL OF PLANNING

(A General Transformation Process)




* NOTE: The planner may enter and exit at any stage

TABLE 3

DEFINING TECHNIQUE STRINGS FOR THE FORMULATION STAGE

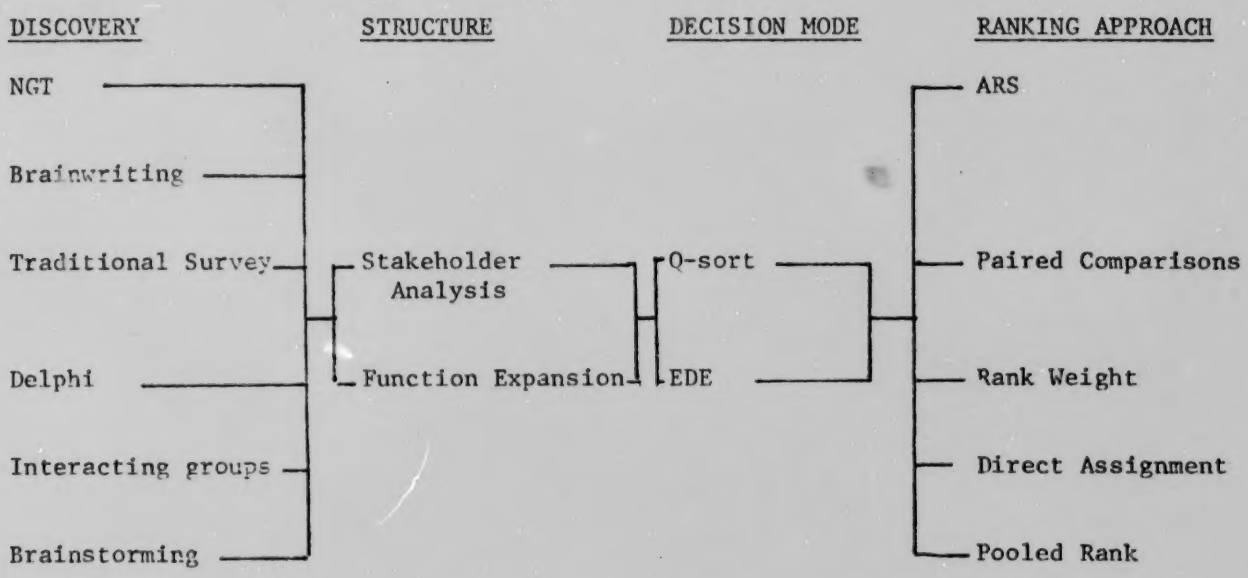


TABLE 4

TECHNIQUE STRINGS FOR CONCEPTUALIZATION

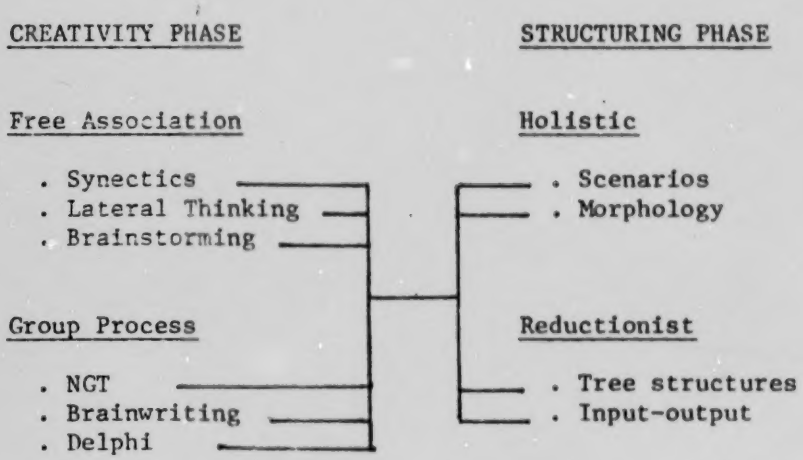


TABLE 5

TECHNIQUE STRINGS FOR DETAILING

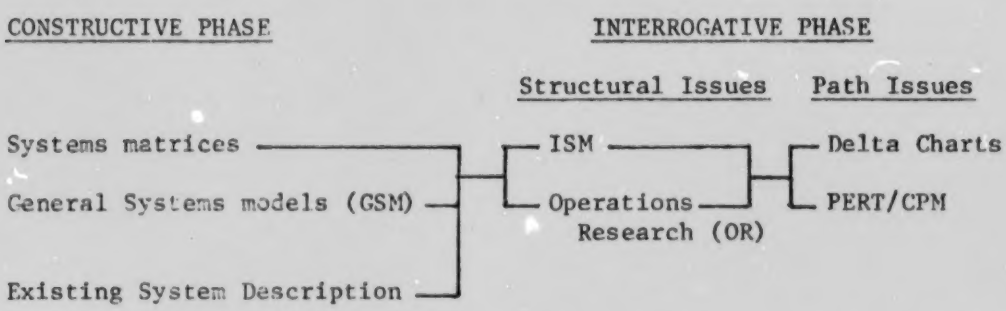
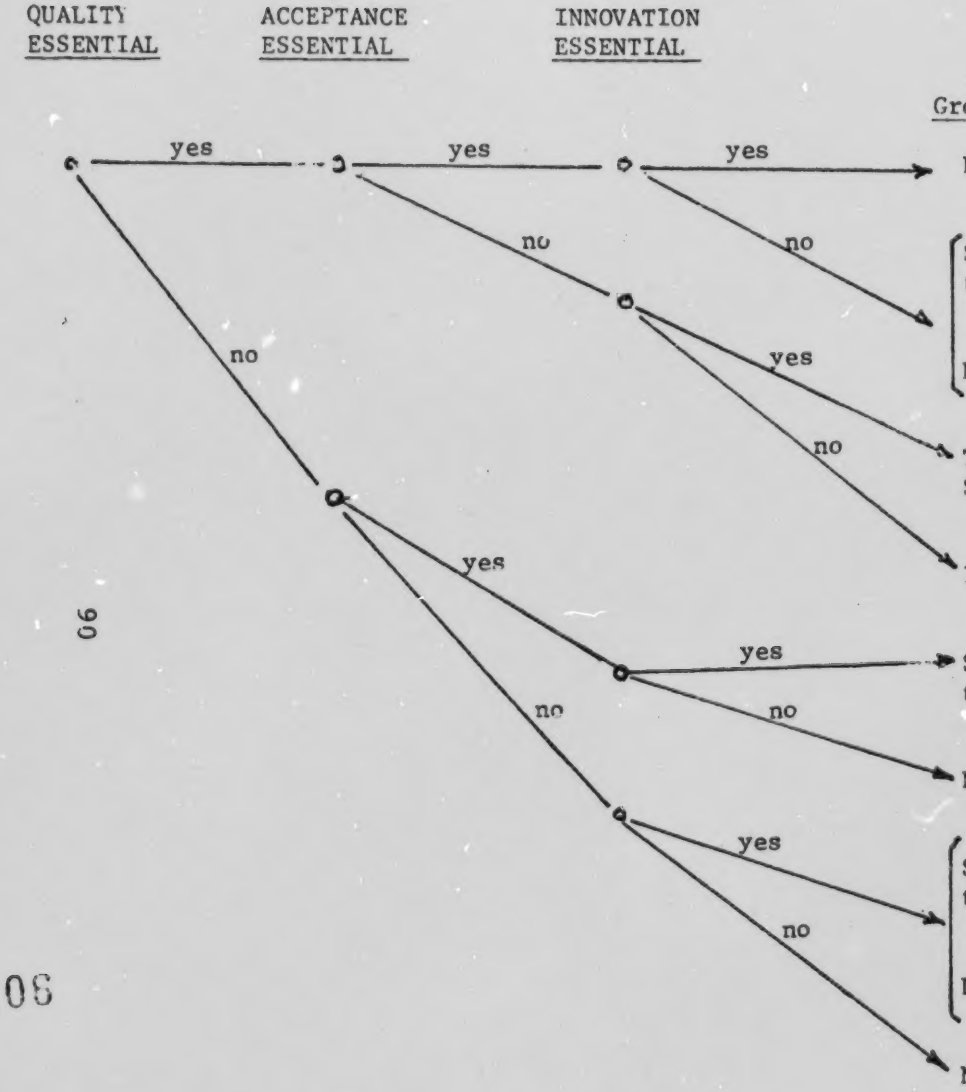


TABLE 6

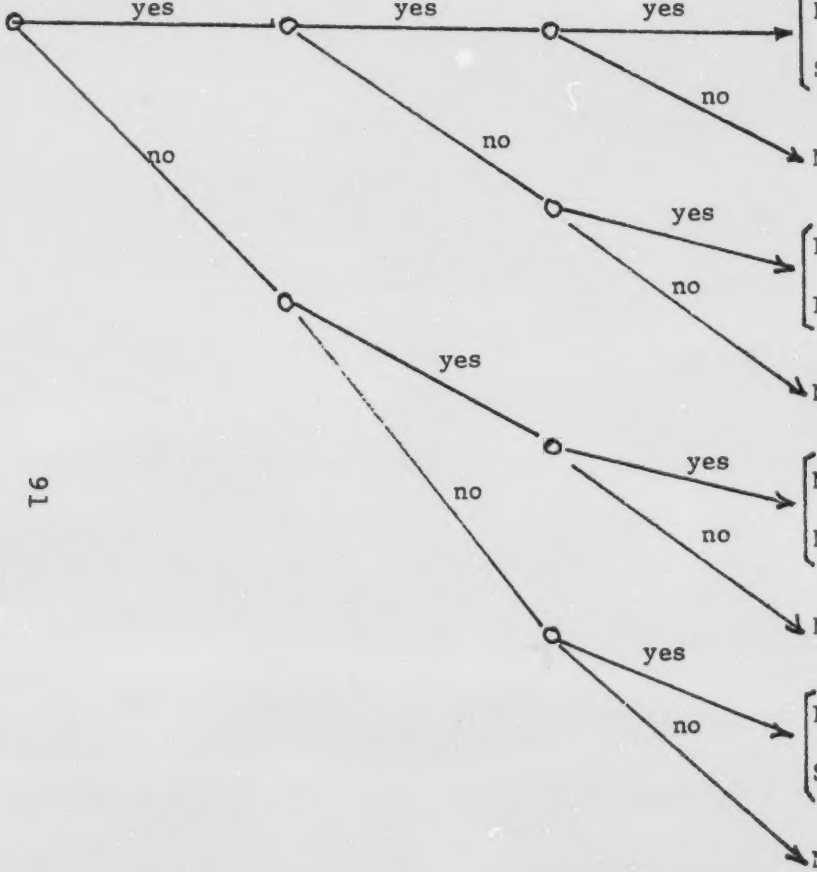
SELECTING A TECHNIQUE STRING FOR FORMULATION




| HYBRID PLANNING TECHNIQUES | | | PATH |
|---|---|---|---|
| Group process | Structure | Decision | |
| NGT | Stakeholder | EDE/pooled rank | 1 |
| Silent Reflective | Function Expansion | EDE/paired | 2A |
| Delphi | None | Q-sort/ARS | 2B |
| Traditional Survey | Stakeholder | None | 3 |
| Interacting | Function Expansion | EDE/paired | 4 |
| Silent Reflective | None | EDE & Q-sort/ARS | 5 |
| NGT | None | EDE/pooled rank | 6 |
| Silent Reflective | None | EDE/pooled rank | 7A |
| Delphi | None | Q-sort | 7B |
| None | None | None | 8 |

TABLE 7

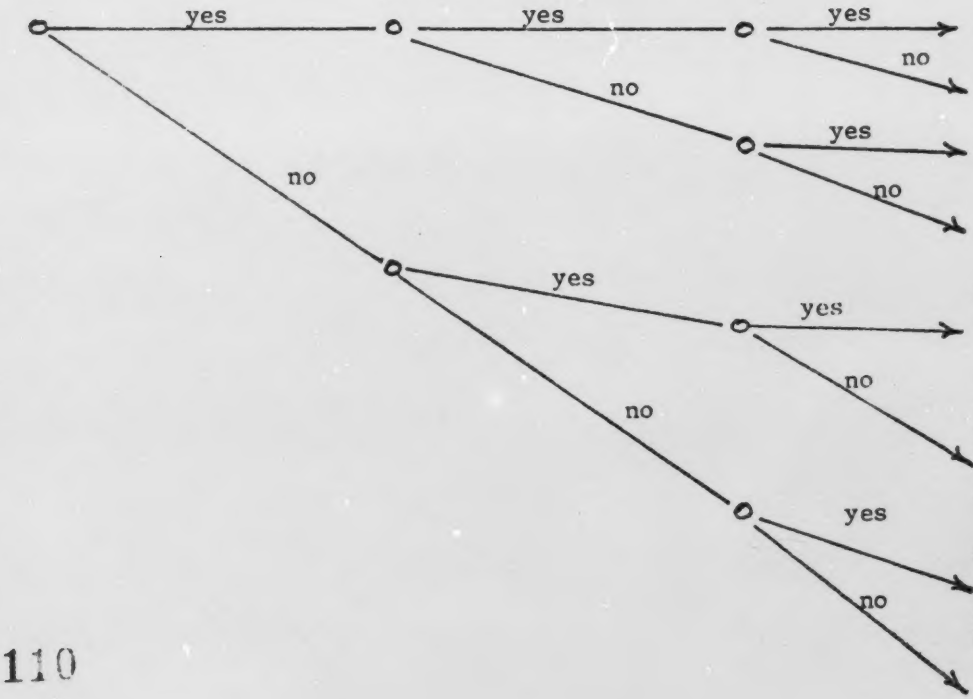
SELECTING A TECHNIQUE STRING FOR CONCEPTUALIZATION




| QUALITY ESSENTIAL | ACCEPTANCE ESSENTIAL | INNOVATION ESSENTIAL | HYBRID PLANNING TECHNIQUES | | PATH |
|---|---|---|---|---|---|
| | | | Creativity Phase | Structuring Phase | |
| yes | yes | yes | NGT | Scenarios | 1a |
| | | | Synectics | Morphology | 1b |
| | | no | NGT/Brainwriting | Relevance Trees | 2 |
| | no | yes | Lateral thinking | Scenarios | 3a |
| | | no | Lateral thinking | Morphology | 3b |
| no | yes | | None | Input-Output | 4 |
| | | yes | NGT/Brainwriting | None | 5a |
| | | no | NGT & Synectics | None | 5b |
| | no | | NGT | None | 6 |
| | | yes | Lateral thinking | None | 7a |
| | | no | Synectics | None | 7b |
| | | | None | Current systems analysis or historical model | 8 |

TABLE 8

SELECTING A TECHNIQUE STRING FOR DETAILING




| QUALITY ESSENTIAL | ACCEPTANCE ESSENTIAL | INNOVATION ESSENTIAL | HYBRID PLANNING TECHNIQUES | | | PATH |
|---|---|---|---|---|---|---|
| | | | Constructive | Interrogative | | |
| | | | | Structure | Path | |
| yes | yes | yes | Systems Matrix | ISM & OR | Delta | 1 |
| yes | yes | no | Current System | OR | Delta | 2 |
| yes | no | yes | GSM or Systems Matrix | ISM | PERT | 3 |
| yes | no | no | Current System | OR | PERT | 4 |
| no | yes | yes | Systems Matrix (NGT with experts and clients in separate groups) | none | none | 5 |
| no | yes | no | Systems Matrix (client system definition) | none | none | 6 |
| no | no | yes | Systems Matrix (expert systems definition with NGT) | none | none | 7 |
| no | no | no | Current Systems | none | none | 8 |

TABLE 9

DEFINING HYBRID PLANNING METHODS

| | FORMULATION STAGE | | | CONCEPTUALIZATION STAGE | | DETAILING STAGE | |
|---|---|---|---|---|---|---|---|
| | Group Process | Structure | Decision | Creativity | Structure | Constructive | Interrogative |
| Path 1 (Quality, Acceptance & Innovation) | NGT | Stakeholder | EDE/pooled rank | (1A) NGT<br>(1B) Synectics | Scenarios<br>Morphology | -Systems Matrix | ISM & OR-Delta |
| Path 2 (Quality & Acceptance) | (2A) Silent-reflective<br>(2B) Delphi | Function-expansion<br>None | EDE/paired<br>Q-sort | Silent-reflective | Relevance Trees | -Block Diagram | OR-Delta |
| Path 3 (Quality & Innovation) | Traditional survey | Stakeholder | None | (3A) Lateral thinking<br>(3B) Lateral thinking | Scenarios<br>Morphology | -GSM or Systems Matrix | ISM-PERT |
| Path 4 (Quality) | Interactive | Function expansion | EDE/paired | None | Input-Output | -Block Diagram | OR-PERT |
| Path 5 (Acceptance & Innovation) | Silent-Reflective | None | EDE & Q-sort/ ARS | (5A) Silent-reflective<br>(5B) NGT or Synectics | None<br>None | -Systems Matrix (NGT in 2 groups; expert/ client) | None |
| Path 6 (Acceptance) | NGT | None | EDE/pooled rank | NGT | None | -Systems Matrix (client define system) | None |
| Path 7 (Innovation) | (7A) Silent-reflective<br>(7B) Delphi | None<br>None | EDE/pooled<br>Q-sort | (7A) Lateral thinking<br>(7B) Synectics | None<br>None | Systems Matrix (NGT with experts to define system | None |
| Path 8 (None) | None | None | None | None | Historical model | -Block Diagram | NOne |

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RESPONSE

by John W. Seavey, Ph.D.
Health Administration and Planning Program
University of New Hampshire

Professor Nutt must be complimented on taking on the monumental task of attempting to integrate planning techniques with the planning process. The field of health planning can be faulted for its failure to contribute to theory building. The tendency within the field is to merely borrow from other disciplines, frequently without much analysis of the appropriateness of such an application. Health planners have become dependent upon other disciplines for advancement in health planning theory and methods. After making the assumption that planning is virtually the same for whatever substantive area to which it is applied, health planners have abrogated their responsibility to contribute to the general theory of planning. Professor Nutt's contribution of developing a paradigm for the utilization of planning techniques is certainly a major one. In addition, the paper is both interesting and provocative, so that it certainly should achieve one of its goals: to stimulate a debate between planning theorists and policy analysts in a productive and useful way. My comments will tend to focus on the implications which the paper has for health planning/health policy curriculum in hopes that they will contribute to that debate.

The initial portion of the paper concentrates on the distinction between planning and policy. Professor Nutt correctly points out that we have tended to mistakenly equate "health planning" with the activities of health systems agencies (HSAs). A curriculum which, therefore, merely teaches students how HSAs plan would indeed be an incomplete basis for understanding the theory and practice of health planning, but this paper's attempt to both combine and differentiate planning and policy analysis results in making both concepts somewhat fuzzy. The paper focuses on planning rather than policy analysis due to the author's self-described interest in planning; however, the imprecise distinction between policy analysis and planning becomes somewhat critical.

The introductory paragraph notes that both planning and policy analysis are typically described in process-like terms; a plan (policy) is the result of the process. But policy is a very loose and amorphous concept. One political scientist, Thomas R. Dye, has defined policy as "the value commitments of the political system."[1] Planning may indeed be one source of policy, but there are so many other sources that one cannot say that "planning makes policy." This is particularly notable in the United States, where the political culture creates a hostile environment for the role of planning and planners in determining policy. This paper attempts to draw together too tightly the concepts of planning and policy. Just as health planning should not be equated with HSA planning, policy (or policy analysis) cannot be equated or too closely identified with planning.

This lack of distinction between planning and policy analysis has implications for the substance of this paper. According to Professor Nutt, one of the major distinctions between planning and policy analysis is that the latter "appears to start with a solution and work backwards to see if the solution is viable." The paper develops paths which employ alternative

techniques (as a guide for students and practitioners) as to which techniques are appropriate during the first three generic stages of planning (formulation, conceptualization, and detailing). There are eight different paths to choose from, ranging from "Comprehensive Planning" which is characterized by a high degree of (1) quality, (2) acceptance, and (3) innovation, to "Gesture Planning" where none of those three criteria are important.

One of the problems with this type of a paradigm as a guide for selection is that it would be uncommmon for any planner to admit up front that he or she was doing anything but comprehensive planning. Few would say that given situation "X" what we should do is to take Path 8 and do "Gesture Planning." The three generic criteria by which paths are to be judged (quality, acceptance and innovation) are critical to all planners. If this is so, then the proposed paradigm becomes more useful as a critique of past planning efforts than as a guide for planning students as to what planning techniques should be selected. For example, according to the paradigm one could identify, by noting the techniques used, which path a planning process has used and thereby be able to identify how the planners weighted the importance of quality, acceptance and innovation. If this paradigm were to be commonly used in practice, one could immediately spot "Gesture Planning" by the techniques used. This, of course, might set off defensive planning, whereby planners would avoid using certain techniques at various stages in order to avoid their activities being labelled as "Gesture Planning." While this is admittedly an overstatement of the point, it does raise some valid questions. Perhaps a point which becomes lost in the proposed paradigm is that techniques, while perhaps not neutral in terms of quality, innovation, and acceptance, can be done well or misused. How techniques are used and interpreted is as important as what techniques are used.

A second problem which this paradigm raises is that it implies to some extent that the planner has reached a solution prior to the planning process being initiated. For example, Path 6 ("Seductive Planning") emphasizes the criteria of acceptance. Therefore, according to the paper, in Stage One of the planning process a planner would use Nominal Group Techniques but have a plant within the group to espouse the ideas which are consistent with the sponsor's preconceived ideas. Using this as a teaching paradigm, one would be focusing on the planning process as a political tool (which it can be) rather than as a problem-solving process. While it is important for students to be aware that no technique is value-free, the selection of techniques based upon the planner's (or sponsor's) weighting of quality, acceptance, or innovation seems too manipulative as a teaching or research paradigm. It is here that one is brought back to the paper's lack of distinction between planning and policy analysis, for here planning is also envisioned as having a solution and working backward--the paper's basic characteristic of policy analysis vis-a-vis planning.

Finally, a comment regarding the implementation of such a paradigm is appropriate. The paper develops alternative paths with their attendant techniques. In the conclusion of the paper, the author notes that "planning is profoundly influenced by a variety of environmental and contextual factors," e.g., whether planning is to devise new ideas or modify an existing structure. While one cannot expect a single paper to integrate all elements, these environmental factors which may become critical are lost in the paper.

Techniques are to be selected based upon a weighting of quality, acceptance, or innovation. The reality is that the planner may desire to utilize many techniques, but that the constraints of such things as time, money, and the availability of meaningful data prevent some of those techniques from actually being utilized.

The criticism being made here is not that the reality constraints are not recognized by the paper, but they are not given their proper weight. One is reminded of Banfield's classic description of rational comprehensive planning and then his empirical observation as to how little planning actually took place and how little of what was taking place was indeed rational.[2] These environmental constraints on planning are appropriate to the selection of planning techniques, especially in a heuristic paradigm. The recognition of these environmental constraints does not invalidate such paradigms, but only puts them within perspective.

This response to Professor Nutt's paper is intended to raise issues and alternative perspectives, not to demonstrate or refute the validity of any one perspective, and to contribute to the debate called for in the prepared paper. Professor Nutt's paper has made a substantial contribution to the field of health planning as well as the teaching of health planning, and it may well become a seminal paper in the field.

RESPONSE

by Colin C. Rorrie, Jr., Ph.D.
Director of the Bureau of Health Planning
Health Resources Administration
Public Health Service

I have been asked as a practitioner to respond to Dr. Nutt's paper on hybrid planning methods. In so doing, it will be from several perspectives--

(a) As an administrator of a federal health planning program;

(b) As a part-time faculty member of a graduate program, responsible for teaching an introductory course in health planning; and

(c) As an interested observer and participant of planning within the institutional setting.

As I pull these perspectives together, there are certain generalizations which I would like to advance. They are:

(1) On the whole, there is a general impatience within our society with long, drawn-out decision-making processes. The focus is often on the decision (making it quickly) and with little thought of process (why we are making it and what the overall context and cost are within which it is made).

(2) The concept of planning within the health industry does not generally show much relationship between the theoretical construct of planning and the reality within which it takes place.

(3) Graduate programs have a major role to play in introducing the concept and practice of planning and its importance, particularly to the institutional setting. Unfortunately, more of the focus is on theoretical elements and not much on its pragmatic importance or the practical realities of planning.

With these broad generalizations as background and from the perspectives I started with, some thoughts arose on Dr. Nutt's paper. The paper deals with a very diffuse concept--"planning" in a structured format of hybrid planning methods. As such, the paper presents a substantial amount of material consisting of a variety of decision-making processes. This is one of the real strengths of the paper; however, in its strength it also gives me certain concerns.

The first of those is that the paper's primary focus is on describing a number of decision-making processes that take place within a planning process, and there is little emphasis on the techniques necessary to carry out effective health planning. Probably a more descriptive title would be "Hybrid Decision-Making Processes."

Specifically, there is little or no emphasis on health resource allocation, cost-benefit or cost-effectiveness analysis, epidemiology as a primary source for information on health care needs, or the statistical base needed for health planning (to mention just a few of the basic hallmark planning concepts that are so well documented in the literature). It is interesting that a review of the paper's bibliography shows very few health or health planning citations. This problem would be largely resolved if the paper were restricted to decision-making processes.

In a related point, the paper makes an unusual statement on policy analysis in the introduction which I believe needs to be re-examined. While it is probably always true that "planning is policy producing," it is not necessarily true as contended, that policy analysis "differs from planning in that it starts with a solution and works back to see if it is viable." I believe that both planning and policy analysis can legitimately begin with identifying issues and problems, and move toward setting priorities and establishing goals. Parenthetically, it should be noted that policy analysis also has its roots in economics, not only political science.

Second, a number of the processes are quite complex. I believe their usefulness would be emphasized by more development of the terms and approaches. The paper assumes everyone has a clear understanding of the various terms used, which I do not believe is true; the readers therefore need more stress on some of the practical implications of selecting one technique over another. This includes such issues as cost of using a process, time required, information needed, and size of organization to support a particular process.

Third, I think we need to address more of the practical realities of the environments in which we are trying to introduce planning. How often is one able to introduce any one of these processes and see it run its full course unblemished? Rarely, I suspect. What I see happening is more bits and pieces being utilized. As far as health systems agencies are concerned, there has been more community frustration over the elaborate process and its lack of relationship to reality and substance than probably any other issue. Within the institutional setting, one sees some of the same. There are questions such as, "Why do we need this elaborate planning process that stresses strategic thinking, markets, goals, needs? The sooner planning helps us produce a Certificate-of-Need and gets it approved, the better off we will be."

The point here is that some of these processes may be appropriate for one institution, but not another. The size of an organization, its structure, its governance, and its function will have a major impact on the decision-making process it undertakes to engage in planning. From the standpoint of the health planning program, the elaborate process set forth in the statute reflects a Congressional desire for there to be simultaneously a large number of stakeholders and a large number of problems to be addressed. The resulting process, including access to it from all sections of the general public, had to be such to accommodate them.

Fourth, a strength of the paper can be found in the evaluation framework that is proposed for judging the results of planning and/or decision-making. This is particularly true in that it focuses attention on what planning is expected to achieve by those undertaking it. But more could be done in the

paper to discuss the interaction among the three major criteria that the paper cites (quality of solution, acceptance, and innovation). For example, the more acceptable a plan becomes to those who might block its implementation, the less innovative that plan will be. The higher the state-of-the-art of the plan, the more likely it is that the plan will be seen as "technocratic" and hence less acceptable.

The point here is that organizational behavior, and the political and economic stakes of those involved in planning, will play critical roles in judgments that are made on a plan. The broader the "ownership" of the planning process, the more viewpoints there will be in that process' results. Our experience has been that no matter how true and valid your facts may be in a plan, the perception of those facts will be different depending upon where one finds oneself in the political context. It is precisely this point which argues for a knowledgeable and systematic approach to selecting a decision-making process by which competing interests can be resolved--hence the strength of this paper.

Finally I believe the paper needs to address the sequence or position it would occupy in the planning curriculum. Is this the beginning element in the sequence, the middle or the end? In any case, the paper needs more development to help the student get into the various hybrid processes. By itself, the paper is quite complex and is often difficult to follow; by the end it is very difficult to sort out the various examples, especially the technique strings and the paths. I believe there are few students who would feel comfortable with this document as it now stands as a focal point in a course on planning. As I have already emphasized, there are a number of practical realities which need to be addressed.

In conclusion, I have attempted to look at this paper from the role of a practitioner and that is the way my response is oriented. I believe the paper has gone some distance as a contribution to a curriculum for health planning, policy and marketing but primarily as a guide to selecting decision-making techniques. I firmly feel its real potential can only be achieved if some of the same issues I have set forth are addressed within the paper.

## DISSCUSSION SUMMARY

by T. Van Ellet

The presentation by Dr. Nutt sparked a lively debate among conference participants, the comments and questions generally falling into one of two major categories. One part of the discussion dealt primarily with Dr. Nutt's presentation on hybrid planning techniques--its complexity, its inclusion in the health administration curriculum, and its utility in facilitating policy-related and other forms of decision-making. The second part of the discussion addressed a number of broader issues relating to curriculum assessment, design and change. As part of this discussion, participants were especially concerned with several normative questions: how should curriculum assessment be undertaken? who should be considered to be the "clients" of the educational process (i.e., employers or students)? how and to what extent should client needs determine course design and content? and what should be the proper role of institutions of higher learning in setting educational standards or in reacting to market forces?

### Hybrid Planning Techniques

Reaction to Dr. Nutt's presentation was generally quite favorable. Among other positive comments, participants noted that the systemization of the various diverse planning methodologies and literature represented a remarkable academic undertaking. As a result, both students and practitioners should be able to better understand and visualize the complexities of the planning process.

Some individuals were concerned that the hybrid planning methodology might itself be too complex, and thus difficult to use as a teaching aid or in every-day decision-making. Other participants felt that the hybrid system, despite its acknowledged complexity, did not go far enough in encompassing all of the criteria necessary to determine the "streams" of options available in the planning process. For example, it was noted that the matrix of planning techniques and options did not include all relevant variables, such as time and political values. Dr. Nutt agreed with this observation, but also noted the "trade-offs" inherent in attempting to present even more information and detail for the reader. Too much material would result in "information overload," affect the clarity of the information being presented, and make the reading and assimilation of the data more difficult if not impossible.

The complexity of hybrid planning was also raised in another context. Specifically, since much "planning" is done either for legislative decision-making, which is often short-term, or for other projects requiring quick decisions, could this technique be used effectively to formulate better policy decisions or to enhance the policy-making process? Dr. Nutt's response on this matter was that the hybrid techniques were probably not all applicable to policy-type decision-making. If used appropriately and selectively, however, he felt that these techniques could help one understand the values underlying the decision-making process and impose some structure on what is considered a very amorphous process. It was generally agreed that a great deal of work needed to be done in this area.

How hybrid planning techniques could be included in health administration curriculum was also discussed in some detail. Dr. Nutt related his own method of teaching this material as follows:

- Students are given numerous studies and articles (e.g., Mintzberg) that provide them with a contextual setting for the material and an overall sense of the issues.

- The different techniques are assigned and discussed with the students, who are then responsible for developing an illustration of each individual technique. The review and exploration of the specific planning methods takes about five weeks.

- Students are asked to "profile" these techniques as they are used as part of the actual planning process. For example, students are required to observe and document the activities of a local HSA or consulting firm. Their observations of these processes, developed in the form of a case study, include information detailing how the planning and decision-making were executed, what techniques and processes were used, and (most importantly) what strategy the sponsor of the planning initiative used in presenting the materials and in influencing the desired outcome of the planning effort.

- The class reviews and discusses each student's findings, concentrating on the processes and techniques contained in the case studies.

Curriculum Assessment, Design and Change

Much of the discussion during this session focused on the many issues surrounding the relevance and assessment of curriculum. Participants were all in agreement that input from former students, practitioners and prospective employers would be invaluable in assessing course content and utility. Not only can this type of dialogue assist the faculty in making necessary changes in curriculum, but it can also help in producing a more marketable student "product" and enhance the reputation of the individual program and the university. It was also noted, however, that very few health administration departments have undertaken an extensive evaluation of their curricula in this manner.

Several participants explained in some detail why they felt that this type of self-assessment was absolutely necessary and provided some excellent examples of how several administration programs had recently undertaken or completed such an effort. The results have been impressive, and have led to extensive changes in curriculum design which made their program much more competitive with other programs from around the country. Essentially, the individuals supporting this type of evaluation felt that it is vital for faculty to document whether their own perceptions of the needs of the students--what it is that they should be learning--corresponds with the knowledge and skills needed to get a job and to function effectively in the real world.

In responding to a series of questions on these issues, Dr. Nutt noted several problems associated with this type of approach to deciding what should be taught. These included the following points:

- It is often very difficult to ascertain who the clients of education really are--the students or the prospective employers. Moreover, the environment and the clients do change over time, as evidenced by the shift in planning done by the HSAs.

- One cannot assume a program's clientele; this must be carefully studied. For example, it is often thought that most planning is done in hospitals. Consulting firms may, in fact, be doing most of the planning.

- The user or client may not really have a sense of student learning needs or health planning as a field of study--their perspective may be too narrow or specialized. Comments from these outside sources, therefore, should be considered, but should not necessarily be the guiding force in determining curriculum content.

- Faculty has the responsibility to apply normative values to course content in deciding what information or skills should be included in a field of knowledge. They must seek a balance between the "vocational" information required to secure immediate employment and theoretical concepts that have less immediate relevance but which are the basis for long-term career development.

- Universities do not offer many incentives to change curriculum drastically, especially in an era of scarce resources. Even with adequate money and time, however, serious problems can result from changes in curriculum, such as conflict among the faculty, which can last for many years.

The session ended with the comment that there is richness in diversity and that different kinds of health administration programs are needed to serve different clienteles. Some programs, therefore, should be primarily reactive and sensitive to market forces. Others should look towards the future and not be so concerned with today's issues and problems. Both have an important role to play in the educational milieu.

# CURRICULUM IN INSTITUTIONAL PLANNING FOR PROGRAMS IN HEALTH ADMINISTRATION

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## Introduction

Not so long ago this paper would have been entitled "hospital planning" or "facilities planning," but that no longer seems entirely appropriate. The changing structure of the health care system is compelling us to change our terms, and with them the curriculum we use in the classroom.

Hospitals are no longer confining their activities to the services that the public views as "hospital" services. The terms "strategic planning" and "corporate planning" are now in vogue in the hospital industry for this reason. These terms suggest a much more diversified industry, more willing to provide a range of services that changes with both organizational and community goals. The hospital industry is also rapidly changing through mergers, acquisitions and shared service agreements. "Facilities planning," with its emphasis on construction and architecture, has only a small role to play in these changes.

Hospitals are also not the only institution in their communities. HMOs, large multi-disciplinary group practices, geriatric centers, extended-care facilities and nursing homes can undertake an institutional planning process. Some hospitals have also brought one or more of these types of organizations into their corporate structure, and must create a corporate plan for all of its units.

Health administration programs must teach institutional planning in order to prepare their graduates for the health care system that is emerging in this country. This is only one of the issues faced by faculty trying to teach planning. Some of the others which I will discuss in this paper are:

1. Coming to an agreement on the objectives of planning.
2. Trying to understand how health care institutions define the role of the planner, and what skills and knowledge that role implies.
3. Forecasting the environment in which our graduates will work, especially the regulatory controls that will exist, and the competitive environment of health care organizations in the future.

We will not be able to come up with any definitive answers today. We have to recognize, however, how critical the answers are for curriculum development. I will propose in this paper that what we need is one or more textbooks and good cases for use in teaching. Writing these requires some response to the issues I have just raised. We need to talk about those issues

first before we can make progress in specifying a curriculum and the resources that we need for teaching.

## Objectives of Institutional Planning

Institutional planning is a process, and it should involve a wide range of individuals in the organization. Planning is therefore not just the writing of a plan, nor is it done solely by the planner or planning department. It is a function of management, assisted by staff personnel with specific skills and knowledge. A major part of curriculum development should be devoted to defining what skills and knowledge managers and planning specialists should have. This varies, however, with the major objective of the planning process.

Institutional planning can have a number of major objectives:[1,2,3]

1. To respond to the external threats represented by government actions;
2. To respond to the threat posed by competing organizations;
3. To find a way to handle conflicting personalities and definitions of what the organization should be doing, especially in regard to the development of a budget;
4. To respond to community health needs; and
5. To bring about a desired organizational future.

The last objective is the major focus of what is called strategic planning. The strategic planning process must address all of the other objectives. Institutions may, however, become pre-occupied with one of these other objectives. This is reflected in the skills and knowledge that they expect to see in the individual they hire to assist in the planning process.

It is crucial that educators understand the differences between organizations in their major objective for the planning process. Consider, for example, the following two job descriptions for hospital planners:

### Director of Corporate Planning

We are seeking an individual to work with the president and trustees of a major medical center to develop a strategic planning process. This individual must have four to five years' work experience in both hospital administration and planning. A masters degree in hospital or health administration or an MBA is required.

### Hospital Planner

Should be experienced in the preparation of CON applications for the acquisition of capital equipment, the modification and provision of services, etc. Strong writing and research skills essential. Health insurance or health planning experience desirable. Should have a master's degree in health planning or health administration and at least two years' experience.

The first individual is likely to spend much of his or her time developing an internal consensus concerning the hospital's mission, goals, objectives and alternative means of reaching them. The second individual is likely to spend

much of his or her time attempting to clarify what various groups and individuals in the hospital want in order to prepare a reasonable justification for the regulators and bankers whose approval is critical to the development of particular projects.

Which type of individual should graduate programs in health administration be trying to train? Many of us would respond that the hospital planner described above should acquire his or her specific skills and knowledge on the job, that the knowledge needed to complete CON applications is not what should be acquired in graduate school. Many of us would also have to admit that our programs do not provide the training necessary to become the director of corporate planning either. Those of us in schools of public health might say that this person is best trained in business schools (that teaching "strategic planning" for a corporation, even if it runs one or more hospitals is not our job). On the other hand, programs based in business schools may be quite comfortable training such individuals within their programs or through courses in other departments.

The greatest challenge in developing curricula in institutional planning is to decide who it is we're training. Unlike those for director of personnel or comptroller, the job descriptions in this field vary widely and change rapidly. In fact, I have seen one job ad that could easily been for a hospital planner, but carried instead the title, "Director of Market Development." Table 1 attempts to summarize the alternative role models suggested by my list of organizational objectives for planning, as well as to suggest some of the skill and knowledge differences. I am sure that we will differ on the importance of each skill or knowledge competency. Weighing their importance is, however, a critical step in curriculum development.

Regulation

One critical piece of information which health administration faculty do not have, and which greatly complicates curriculum development, is an understanding of what federal and state regulation in the health field will look like even one year from now. Those of us who have lectures prepared on federal requirements for Certificate-of-Need review, for example, are not sure how relevant they are to the future of our graduates.

In order to develop a curriculum, we need to look at state and federal regulation as two separate but interrelated issues. The initial push to remove federal regulatory controls may continue or may be followed by even more stringent controls as Medicare and Medicaid costs go out of control, and President Reagan could be forced to emulate another conservative president, Richard Nixon. Whether this will occur, and what those controls will look like, is open to speculation.

What we know more clearly is that the states will be placed under greater pressure to assume control over Medicaid spending, and that some states have in place regulatory controls which could be strengthened, e.g., rate-setting and CON review. Other states that have not been deeply involved in regulation, faced with more responsibility to control costs, are likely to emulate those programs (or limit eligibility and benefits).

The result is that institutional planners in many states will have to concern themselves with the public justifications of growth and changes in services to a greater degree. Institutional planners will also have to utilize increasingly sophisticated tools, such as management information systems, to assess the implications of various responses to government controls. Those of us who have worked with either the state or the hospitals in New Jersey as they developed their DRG-based hospital reimbursement system can see where this can lead, and some of the skills that are required.[4,5] Research is needed on the planning uses of the data bases now becoming available, a subject to which I will return later.

The teaching implications of all this are clear. If regulation, especially at the state level, grows and becomes more sophisticated, our graduates will need to understand how government policy is made; have a thorough understanding of the history and intent of regulatory programs; be familiar with the assumptions behind various regulatory tools (e.g., rate-setting formulas); and have the inter-personal skills necessary to deal not only with public officials, but to assist individuals in their organizations to understand and develop productive attitudes toward the regulatory process. Those of our graduates who will work as planners will also have to know how to analyze and forecast information, both clinical and financial, to assist their organization in responding to regulatory activity.

It is still too early to tell what will happen in regard to regulation. I believe that state regulation of the health care system will in fact intensify, especially where adverse economic conditions have weakened the tax base and made paying Medicaid costs difficult.

We also cannot dismiss the possibility that "private" regulation will increase. Private regulation is the restriction of access to capital, and the regulators are the commercial and investment bankers, as well as the boards of autonomous public bonding authorities. Unless interest rates drop, or hospitals join multi-hospital systems with other means of financing, access to public bond monies will become the critical factor affecting growth. While the emphasis on community health status improvement might abate, tough questions will continue to be asked about financial management, the populations being served, and duplication of services in each community. The institutional planning process will have to provide some of the answers.

## Competition

A number of proposals have been made to increase competition in the health care system. The lifting of federal requirements for CON review is just one of them. If greater competition can be stimulated, institutional planning will enter a period where strategy-setting and market development are the major focus.

Accelerating this trend is the growth of proprietary and non-profit multi-hospital systems. Such organizations are likely to develop corporate planning departments that are more oriented toward planning as it is practiced in the private sector, and they will have the resources to use planning tools not often considered by individual hospitals (e.g., forecasting models for utilization as well as financial condition).

The teaching implications of an increase in competition are also clear. Our graduates will have to learn some of the skills commonly taught in graduate business programs. This includes strategy-setting, market analysis, and the analysis of competitive strengths and weaknesses.[6,7,8] Marketing and financial management skills will also be very important. Many faculty, especially in schools of public health and public administration, are not used to teaching planning with an emphasis on a single institution. Rather, we have taught that the institution is a part of a system to improve community well-being, and that the community's welfare should take precedence over the institution's. Training students to place the institution at the center of importance seems unholy.

Since by education, personal commitment and experience I fall into this group, I have several comments to make. First, we must continue to place the needs of the community and its people at the top of the list of our priorities. Our students, however, will take jobs in institutions which place their own growth and survival at the top of the list. This may be because the institution feels it acts in the community's interest; it may be because the organization feels that a good rate of return on the investment of its share-holders is an obligation of management; it may be because of the ambition of its executives and physicians.

If we fail to teach our students how strategy is formulated and executed for individual institutions, we lose in several ways. Those students headed into government will not understand the perspectives of the institutions they regulate. Those who are headed into those institutions will be less effective in their jobs, at least until they learn on their own.

I believe the job of programs in health administration is to teach strategy-setting and implementation within the context of the community's health care system. We need to show where the institution-centered perspective works (i.e., leads to desirable and equitable outcomes for the community). We also need to teach students headed for both government and the private sector how to tell when it is not leading to improvements in community health. The growth of one institution over another does not necessarily lead to a less than optimal improvement in community health. In fact, we all have our favorite hospitals, HMOs, and nursing homes that we take our students to visit because they illustrate the good that institutions can do in the community.

What we are concerned about--and the need for concern is genuine--is that the weakening of the community planning process will lead to the development of health services that do not benefit consumers as much as professionals within institutions. But failing to teach our students how to help their institutions compete effectively only worsens that problem. It leaves to the MBA and other non-health programs in the business schools the task of training students to guide health care institutions.

It is my belief that we should train those headed for regulatory positions in the states and other levels of government in the same classroom as the future planners of institutional health services. Both should learn the other's point of view. In order to do that, faculty will have to learn both viewpoints, and for some of us, that means moving beyond our expertise in community health planning to develop knowledge and skills in strategic planning. Inviting in an instructor from the business school is not enough,

although team-teaching may be a solution. Sending our students to take marketing and strategic planning courses in the business school is not enough. The community's and the institution's perspective on the health care system must be clearly related.

## Resources for Curriculum Development

### Texts

Health administration faculty lack two important resources for teaching institutional planning--one or more good texts, and case studies on a variety of organizations, planning processes, and problems.

Ideally, a text should provide an introduction to both of institutional planning's two major tasks, i.e., strategic planning and responding to the public policy and regulatory processes. Such a text has yet to be written. I do not have the time in this presentation to discuss with you the limitations of every book currently available. What I would like to do instead is describe what an appropriate text would look like and assert that none of the ones now available meet these criteria. This may encourage someone in the audience to write it.

The text we need would begin by explaining the two perspectives on health care institutions now prevalent. First, that they are organizations which, because of their level of public support, should be viewed as components of a larger system designed to serve the community. They are therefore subject to controls to assure the proper functioning of the system for the benefit of all. Secondly, that institutions are also social organisms with a history, mission, and resources. Those who have invested energy and resources expect them to survive and achieve certain purposes.

The text would then move to explain how planning is done from these two perspectives, and the contributions and conflicts that each perspective leads to. It would examine, for example, the question of organizational survival from both perspectives. Considerable time would then be spent on the interactions between institutions and public bodies concerning the planning of institutional services. This would include the structure of those relationships--as well as the more informal processes that occur, especially involuntary community planning.

Strategic planning would then be explained. The text would take a look at the many common techniques of community and institutional planning in regard to needs assessment, financial analysis, priority setting, the selection of alternative actions, plan implementation, and evaluation.

The final part of the book would return to the question of how the two types of planning can co-exist. This is not as impossible a task as it might first seem. An effort has already been made in the area of marketing to identify what elements of that process are compatible with public policy objectives. The idea of an exchange relationship, in which both parties benefit, is one such concept.[9]

The text should have as its objectives:

1. To present an understanding of the inter-personal and political processes involved in both strategic planning and the planning required by the public sector;
2. To explain the techniques available to both regional and institutional planners, and where they overlap; and
3. To explore the compatible elements and conflicts involved in both meeting public planning requirements and preparing an adequate strategic plan.

Such a text would recognize that our students are likely to live in a world where health care institutions are neither nationalized nor operating in a free market environment.

Case Studies

Finding case studies for use in teaching is also a problem. There are two potential sources--the "public" institutional planning process and the "private" strategic planning process.

The public process yields some information useful in developing case studies. The richest sources of information on institutions are the prospectuses prepared to support the issuance of bonds by public authorities (e.g., Medical Care Facilities Finance Agency in New York or the Health Facilities Financing Authority in New Jersey). Public authorities, investment bankers and the bond-rating services (i.e., Moody's and Standard and Poor's) pose similar questions to institutions and their consultants, providing a consistency useful in classroom teaching. One can look at a prospectus from the Midwest and one from New England and find similar questions being posed and answered. Standard and Poor's has prepared a summary of the information it expects to see that can be used to structure student thinking about a case.[10]

Several states (New Jersey, Rhode Island, Massachusetts) require the submission of plans by hospitals. While the questions are consistent, the quality of the response is likely to vary more widely.[3, 11] First, the financing of a desired project is not at risk, and sanctions for submitting a poor plan have not been developed by states. Secondly (and related to the lower stakes) consultants are less frequently used, and hospitals differ tremendously in the quantity and quality of their planning staffs. Certificate-of-Need applications can also be useful to the extent that they address the present and future of the entire organization, which may be the case if a major facility is to be replaced.

I must emphasize again that these are public documents. Even if the questions are detailed and the stakes are high, there is no premium put on carefully documenting weaknesses, the strengths of competitors, trends that may hurt the institution or any other subject that suggests that the institution is not strong. Even in rating public bond issues, doubts are resolved in private, and the weaker proposals eliminated by the prospect of an unacceptable rating. The frank questions that may be asked in meetings with the hospital are not transcribed and presented.

This is also true for CON applications, although questions and answers, as well as independent staff analyses by the state and HSA, are available if the application was formally submitted. Plans prepared for submission on an annual basis may be even less complete, since the states and HSAs rarely have the time to carefully review these documents, and institutions know it. By searching through this public information and applying their own skills, however, faculty can develop teaching cases. Students can also be encouraged to pull together this material and analyze it for term papers and master's theses.

It is the "private" strategic planning process that presents the greatest problem. First of all, it is a "process", and a plan (if one is ever produced) may present the conclusions without the deliberations. Even then, the plan itself may not be available. In an intensely competitive environment, it would be counter-productive to broadcast the institution's plans to its competitors.

This leaves faculty with the job of becoming an observer of the process and asking the institutions to allow, with safeguards, publication of the results. Since most of us would like to remain near our jobs and families, this means asking local institutions for their cooperation. I will assume that some of my colleagues have been successful in doing this. If they have, the results have yet to be circulated. We still need that book of cases, or a case clearing-house for health care institutions similar to or part of the Intercollegiate Case Clearinghouse.

This leaves many of us teaching more of the theory than the reality of strategic planning. I myself am far more successful at teaching the public institutional planning process, and asking my students to play the role of investment banker, than I am at re-creating for them the dynamics of strategic planning. I try to make up for this by having them read Joe Peter's A Guide to Strategic Planning for Hospitals[1] and McMillan's Planning for Survival[2], both of which suggest some of the human dimensions of the strategic planning process. I am still, however, waiting for access to the case material that would make me a more effective instructor in regard to strategic planning.

I was more or less happy to learn that this is not only my problem. AHA's Society for Hospital Planning also lacks access to hospital strategic plans. It is a joint problem that I hope we can begin working on together very soon.

## Research

My opinions on the research needed in institutional planning are shaped by the studies I have done on the use of information systems in HMOs,[12] on the case-mix data in making capital expenditure decisions on Cardiac Care Units (CCUs)[13,14] and on techniques for assessing a hospital's financial viability.[15]

There is a critical need now to examine more closely how we can use the large amount of clinical, financial and other information being collected on institutions and the people they serve. This would allow us to plan more effectively, both publicly and privately. This interest is shared by AHA's Hospital Research and Educational Trust, which recently received several million dollars to pursue this subject with AHA's Hospital Administrative Services and the Commission on Hospital and Professional Activities.16

The payoff from the large sums of money we are investing in data collection is unclear. We need to develop not only better methods of data analysis, but a much better understanding of how and when administrators, regulators and physicans use information to make decisions.

States like New Jersey[4] and New York,[17] with federal assistance, have created large data bases of information useful in the institutional planning process. It is clearly not their job, however, to help institutions to learn to use this information for planning. I offer you just one question to suggest both the problem and the potential. What would you as an institutional planner do with information on the number and costs of services to patients by DRG? Under what circumstances would that information have any impact at all on the strategic planning process in your institution?

This is an important area of research in the long-term care field as well. As the population in this country ages, more and more time will be spent discussing the needs of the elderly and collecting more detailed information on their condition. How this information can be used in planning long-term care services, including home care, is only beginning to be explored.

What is needed is not just the skills of operations researchers and better tools for forecasting and evaluating alternative courses of action: we need a much better understanding of how information can be used in a planning process that involves a broad range of individuals, including administrators, physicians, and consumers. While institutions may be purchasing computers every day, the real impact of improved information on the planning process has yet to be felt. I hope that faculty in health administration programs become involved in this applied research on decision-making in health care institutions.

## Conclusion

I have argued in this paper that curriculum in institutional planning must reflect the varying objectives for planning that have emerged and are evolving. Unfortunately, this does not leave us with a neat list of skills and knowledge areas that can then be organized into courses. Our curriculum is going to reflect the current disorganization in our thinking about the role of public as opposed to private decision-making in the health care sector. I believe strongly that we cannot teach students that institutional planning only involves assuring that decisions are congruent with public policy and community needs. Nor should we be preparing them to view their institutions solely as being in a constant competitive fight for markets and profits. Reality will be somewhere between these perspectives, and so must our teaching.

But we definitely need better resources for teaching. This will be a difficult process when we attempt to teach the "private" process of strategic planning, and faculty need help from both practitioners and their professional associations. What we can offer them in return are the candid opinions of outsiders about how their work can be improved. I hope that this conference will lead to the development of the case studies we need and will stimulate someone to write the text on institutional planning for the 1980s.

Acknowledgements

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TABLE 1

MAJOR OBJECTIVES OF INSTITUTIONAL PLANNING AND SOME OF THEIR SKILL AND KNOWLEDGE REQUIREMENTS

| Some of the Skills and Knowledge Required | Respond to External Threat: Government | Respond to External Threat: Competitors | Resolve Internal Conflicts | Respond to Community Needs | Reach Desired Future (Strategic Planning) |
|---|---|---|---|---|---|
| 1. Knowledge of Health Status Indicators | H[1] | M | M | H | M |
| 2. Ability to Use Patient Origin & Destination Data in Order to Describe Current Market Segments Served | M | H | M | H | M |
| 3. Ability to Use Priority-Setting Techniques with Professionals & Consumers | L | L | H | H | H |
| 4. Ability to Develop a "Competitor Profile:"[2] (i.e., Prediction of a Competitor's Offensive & Defensive Moves) | L | H | M | M | H |

TABLE 1 (cont.)

| Some of the Skills and Knowledge Required | Respond to External Threat: Government | Respond to External Threat: Competitors | Resolve Internal Conflicts | Respond Community Needs | Reach Desired Future (Strategic Planning) |
|---|---|---|---|---|---|
| 5. Knowledge of Techniques to Improve Public Relations and Communications with the Media | H | H | L | M | M |
| 6. Knowledge of C.O.N. Guidelines & Regulations | H | M | L | M | M |

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1 Note: Relative Importance of Skill or Knowledge to Objective:
H = highly important; M = moderately important; L = low importance

2 Michael E. Porter, Competitive Strategy: Techniques for Analyzing Industries and Competitors (New York: The Free Press, 1980), p. 67.

RESPONSE

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## Introduction

The terms "strategic planning" and "corporate planning," we are told, are now in vogue within the hospital industry. The challenges to organizational mission in response to changes in societal expectations, demographic and disease trends, and shifting policies of government as a major purchaser and regulator of health services have resulted in the recognition of the need for better information, techniques, and processes to identify and cope with the opportunities as well as the uncertainties that are handmaidens of change.

A symptom of this concern includes the emergence of long-range, strategic, and corporate planners on the hospital management staff and the promotion of the concepts of long-range, strategic, and corporate planning activities in the professional hospital trade and academic literature[1,2,3]; the evolution of national, state, and local societies for hospital-based planning; and last but not necessarily least, this Conference on Curriculum for Health Planning, Policy, and Marketing in Health Administration.

Within the hospital sector, what is often referred to as long-range planning or strategic planning has been stimulated in part as a mechanism to cope with regulatory demands, partially as a consequence--and in some cases as a prerequisite--of organizational diversification. In any case, the burden of efficiently managing the multiple tasks of day-to-day operation and deciding the direction in which it should be headed, and the consequent impact of such decisions upon the structure of day-to-day operations in an industry more willing to provide a broader range of services through both vertical and/or horizontal diversification, has created within the organization increasing integrative demands upon a single executive officer.

Typical within hospital settings has been the proliferation of planning titles and positions: directors, vice presidents, and associate administrators for planning, planning and development, planning and marketing, planning and special projects, and planning and management engineering, to name a few. While this empirical evidence suggests that hospital administrators are recognizing the need to bring planning within the institutional framework as evidenced by the creation of planning roles and positions within the hospital, the paradox is that there is little empirical documentation of what hospital-based planners do, what factors are associated with their presence, and what impact their activities are having on the organization and its behavior.

A study we recently conducted attempted to document the activities and roles of individuals identified by chief executive officers (CEOs) in hospitals in six cities (three in upstate New York and three in southern Ohio) as the "individual in addition to CEO, if any, with primary responsibilities

for planning." The individuals so identified were then asked to identify five tasks that they through their CEO considered "most critical to the evaluation of their overall effectiveness." In developing this initiative, we built upon the observations of Burke[4], Fink[5], and Lauffer[6]. The study adopted a two-dimensional matrix model to describe the roles of the institutional hospital planner in terms of his or her task and focus orientations (Figure 1). The matrix views the roles planners carry out within institutional settings in terms of their skill orientations (i.e., analytic/transactional) and in terms of the focus in which these skills are applied (i.e., internal context/external environment). Hospital planning roles within this framework include: the management engineer (number-cruncher); the MBO and special projects manager (honcho); the environmental assessor (market analyst). The last role is the conceptual organizer (a manager and designer of the process of planning).*

These tasks identified in the survey of "hospital-based planners" were then content-analyzed in terms of their internal vs. external focus, and in terms of their rational vs. transactional skill orientation. By and large, the distribution of tasks were bi-modal for each planner, i.e., falling into more than one category twice. In that we were attempting to correlate roles with organizational behaviors, this was initially most disconcerting. By combining primary and secondary roles to create role sets, the following planning role sets can be generated in theory (see Figure 2); however, only Roles I, II, III, and V were found in practice.

| | | |
|---|---|---|
| I. | B + D | Strategy Formulator |
| II. | C + D | Policy Development |
| III. | A + D | Operational Implementation/Control |
| IV. | A + B | Program Evaluation |
| V. | C + B | Certificate-of-Need Jockey |

Historically, as observed by the educational subcommittee of the Society of Hospital Planning, hospitals have defined planning in terms of a very narrow set of technical activities, such as: predicting the demand for hospital services, conducting functional programming, providing architectural design and construction management, and providing liaison between the hospital and capital expenditure review agencies. Given this set of planning tasks, the hospital planner is then expected to possess skills which will facilitate analysis of patient origin data, quantification of use rates and staff requirements, and the comprehension of public planning regulations and guidelines.[7]

Our data indicates that hospital-based planners not only may play many roles at different times, but carry out different role activities simultaneously. These role sets are characterized by their boundary-spanning functions between a) the external-internal interface, and/or b) the technical (and transactional) interface.

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* This framework produces a parallel set of community planning roles (see Figure 3).

An analysis of our data also indicated that:

- CEOs identify hospital-based planning as a job most often done by managers with other line/staff responsibilities;
- you do not have to be called a "planner" to be identified as the planner;
- that just because you are called a planner does not mean you are doing or involved in strategic formulation;
- hospital-based planners most often view their significant role to be facilitators or managers of technical planning rather than as the doers of technical planning.

Therefore, programs in hospital and health administration, in the preparation of individuals to assume responsibilities assigned to hospital-based planners, may wish to broaden the definition of "planning" to include a broader mosaic of functions, roles and role set combinations. It is often said that there is no one best way to plan. A corollary might read: there is no one best combination of roles, and each institution's CEO and planner must adapt the planner's role and the process for planning to its unique external and internal potentials and constraints.

The professional practices, tasks, and role sets identified by hospital-based planners indicate that the planner possesses technical skills which enable him or her to identify and analyze significant forces in the environment and to design relevant transactional strategies directed at influencing internal organizational decision-makers as well as the significant forces external to the institution. While planning may be a "professional practice," we should not confuse planning skills with planning roles. Nor should we confuse planning roles with singular managerial positions. One role attribute and consequent skill requirement that appears to unite these disparate organizational actors is that they all appear to demand the ability to mobilize power and influence others in the absence of direct-line authority.

We may need not only good cases, but good metaphors, to capture the essence of situations in which the profession is practiced. Let me try a few here:

- the INTELLIGENCE AGENT, who must convince the boss and/or the board of the external opportunity or crisis at hand;
- the AMBASSADOR, who must create a positive image and good working relationships with potential competitors, regulators and customers;
- the CERTIFICATE-OF-NEED JOCKEY, who manages the C.O.N. application through the capital expenditure review process;
- the GUERILLA WARRIOR, whose concern is bottom-up change initiated and mobilized at lower and middle levels of the organization (a strategic practice not uncommon in overly-managed and bureaucratic settings);
- the GESTALT THERAPIST, that internal conceptual hairsplitter who keeps asking, "Are we asking the right questions?" and "Is the strategic whole greater than the sum of its policy parts?";
- the DEVELOPER, who stakes out organizations with potential for acquisition and/or potential stakeholders necessary for the creation of new external ventures, or new internal systems of operation;
- the META PLANNER, whose responsibility is to design, implement, and facilitate the process of planning at, between and within the corporate, local, and departmental levels of the organization; and

- the COMMANDO RAIDER, who must honcho the strategic decisions into ultra-organizational and interdepartmental actions with the precision timing and PERT-chart accuracy of a commando leader, with or without the initial commitment and cooperation of the line generals to whom his temporarily-assigned troops traditionally report.

If we can describe these role sets within situational contexts which include the articulation of organizational resources and potentials, along with environmental demands and constraints, then the inherent conflicts of interest between and among individuals--not only as theoretical abstractions, but as case situations--will allow our students and ourselves (as faculty and as practitioners) the opportunity to immerse in the details of the organization and its environment. Thus we can come to understand and indeed empathize with the major participants on all sides of the issues, and to think through the range of options and probable interactions and consequences of the sets of policy decisions we make and the decision processes we are asked to design, structure and manage.

Ray E. Brown, the pioneer in the field of training for health administration, in promoting the field experience as a didactic tool, observed that:

> "Just as the laboratory is a necessary supplement to the study of all sciences, so is the means of observing actual hospital operations needed to enable the student[s] to visualize the subject they are studying."[8]

For Brown, "student participation" in such field experiences, for many reasons, was limited to that of "observer." In a later treatise on curriculum for health service managers, Brown observed that:

> "The mission, ownership, governance, financing, staffing, and services of the health services enterprise are substantially different, and in instances at odds from that of enterprises in other fields of endeavor. The same is true of its external relations with consumers, the public, and governmental agencies at all levels. While much of this difference can be learned on the job, some of the most important differences are subtle and complex, and are not readily gained in practice. Neither is experience a good organizer of the thinking of the practitioner on some of these differences."[9]

The field experience, I believe, continues to be a viable mechanism for exposing students to the dynamics of the internal, day-to-day operation of the hospital. We need to consider promoting the use of the case teaching method pioneered in health administration by Penchansky and his associates at Michigan[10] and Sheldon and his associates at Harvard[11] as a didactic tool. This tool is designed to provide our students experiential opportunities, decision-forcing and participative roles in the development and testing of their skills in strategic planning, critical problem-finding, organizational structuring, decision-making action mobilization and influence generation

under conditions of both competing external and internal goals and increasing environmental uncertainty. Such preparation may provide our students with a greater appreciation for the role of theory and conceptual framework in the formulation of strategy and in the organization of thinking and action. We hope that it will better prepare them to cope more effectively with the challenges that lie ahead.

The adoption of case studies in the course in strategic planning would appear to be an excellent place to integrate ethical considerations into the curriculum. In addition to case studies, the invitation of practitioner guest speakers would also be appropriate, and would reinforce the message that ethics are a "real world" consideration. This need is particularly acute in strategic issues, in an era where the popular wisdom admonishes our students that our health care institutions, with their historical mission rooted in ethical and cultural purpose, now must be run like businesses if they are to survive. In this context, we must maintain in the minds of our students, as the former Dean of the Stanford Business School has observed, "ethical behavior is good business."[12]

We need decision-forcing cases:

- that test and/or at least awaken our students' sensitivities to the potential consequences of treating the existing internal organization and its functions as ends in themselves;
- that explore the potential consequences of working in an institution lacking a sense of organizational direction, and in stressing one's own self-interest and vice versa;
- that realistically convey the fact that hospital executives must be cognizant not only of their individual organizations, but also of the collective impact of their behavior as an industry if they are to maintain a relative degree of freedom of action; and
- that test our students' abilities to focus, not only on the value of organizational outcomes, but also on the value of the means chosen in deciding the outcomes.

Our curriculum, texts, and cases should address the perspectives of providers, regulators, consumers, practitioners, and educators in order that we may begin to bridge the gap between the perceived political cynicism, entrepreneurial greed, and academic naivete that is often attributed by each group to the other. Before we ask our students to judge the behavior of others, we should ask them, "What would you do if you were in their position?"

While Professor Kropf suggests that our graduates need to understand how government policy is made, and have a thorough understanding of the history and intent of regulatory programs, I would like to add that our graduates should learn to be able to view the future as history, and begin to visualize how the health care organization might progress through future stages in its life cycle.

While our current attention to institutional planning is attracted to the relative explosion of diversification interest and acquisition activities resulting in the emergence of multi-business corporations within the health care industry, we should not ignore the implosive potential of computer-based information support systems which Professor Kropf indicates is yet to be felt.

These systems, along the concepts of DRG, may prove to be more significant in their impact upon internal organizational differentiation and integration than as a tool in community planning and regulations; however, greater experimentation and research is indicated in the design of organizational structures that allocate roles, responsibilities, and relationships between administrators, physicians, consumers and the representatives if their real impact is to be felt.

Specifically, we need to design or identify and evaluate evolved or planned variations in strategic planning structures within the hospital and health care industry, and their impact upon the organization's behavior. We should examine the role of complimentary planning and organizational concepts (i.e., strategic business units, basic business units, and other types of matrix and modified-matrix organizational forms superimposed upon existing operational structures) developed in the business sector in the recognition that "the organizational structure that is best for operations may not be best for planning."[14]

It is now appropriate to summarize this response, and to make some final comments. First, planning is as much a transactional and conceptual process as it is technical. Secondly, our curriculum in planning requires a political paradigm for addressing ourselves to the dynamics of power mobilization and influence that appears to be associated with planning roles and tasks. Third, we need to expand our repertoire of relevant case materials that force our students to identify and articulate the multiple constituencies (including their own self-interest) and their often competing perspectives and expectations of what the organization ought to be doing. Fourth, we must address our curriculum to questions relating to ethical considerations of both the process in and the outcomes of decision-making. Fifth, we need to define and identify the alternative ways in which the process of planning is structured to different initial contextual settings and environments, and to evaluate their impact upon the operational activities we manage in the delivery of health care services and upon the community in which we live.

In conclusion, no one can tell the future--not the world's greatest institutional planners nor the academicians who observe them. But it is the managers whose strategic behaviors, whether by design, default, or simply muddling through, who will bring forth the design of strategic planning systems. By observing these practitioners, we academicians will learn from them and can reciprocate by facilitating the education of their counterparts in the field, as well as those preparing to enter it. It is to be hoped that the structure of conferences such as this one will stimulate their experimentation, facilitate our learning, and promote opportunities for such reciprocation.

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## DISCUSSION SUMMARY

by Carol Barbier Rolnick

Initial discussion responded to the recommendation by both Dr. Kropf and Dr. Gerowitz that case teaching should be included as a major segment of curricula for institutional planning, as an important method of immersing and educating the student in the roles and situations of the organizational setting. While advocating this approach, however, both Drs. Kropf and Gerowitz commented on the general unavailability from hospitals of case material to provide adequate, simulated institutional planning experience. Both noted that this lack of information could be attributed to the guardedness of institutional planners, and the duality of the public and private planning processes engaged in by health care institutions, particularly hospitals.

While most respondents concurred with the value of the case teaching method, several participants challenged the assumptions of the two speakers that material was unavailable and that hospitals were unwilling to share the "private" planning experience. Some participants suggested that perhaps closer working relationships should be established between academicians and their colleagues engaged in institutional planning as a means of eliciting more cooperation and support in training students appropriately for institutional planning needs. Mara Melum of the Society for Hospital Planning suggested as an alternative that established educational programs, such as those sponsored by the American Hospital Association and others, could also be rich sources of case study material.

Dr. Gerowitz added that an additional obstacle in using the case teaching method was relating the theories and concepts of institutional planning to the case "practice" sessions in the classroom. Several participants responded with questions and suggestions for best utilizing cases as a teaching method. There was general concurrence that role-playing, while difficult and time-consuming, was the most successful method in using case studies in the classroom.

Discussion returned to the availability of case studies and other materials, specifically texts, for use in planning curricula. Suggestions included the establishment of a form of clearinghouse, privately operated, and an inter-university cooperative for exchange of curriculum ideas and material, as well as continuation of this form of conference. It was noted that a text on strategic planning by Joseph Peters and James Webber was in its final stages and would be published by the American Hospital Association within the year.

# A MARKETING CURRICULUM FOR HEALTH SERVICES ADMINISTRATION

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## Definition

The definition of marketing as applied to health services administration is particularly critical to discussing curriculum. Conventional wisdom tends to think of marketing as a combination of packaging, advertising and selling, with emphasis on encouraging people to buy more of what the organization has to sell. Marketing professionals, such as Kotler, Zaltman and Vertinsky deal with marketing much more broadly. They define it in terms of designing and managing exchange relationships with important publics, i.e., groups of people or organizations who do or might engage in transactional relations with the organization. This latter definition could easily be taken to include the entire scope of health services administration: professional relations; personnel and labor relations; public relations; customer relations; trustee, volunteer, financial, regulatory and essentially all relations.

Since much of what might be construed as marketing is already addressed under existing administration rubrics (management, labor relations, planning, etc.), the challenge in defining marketing for curriculum development purposes is to identify where marketing differs from, and what it adds to, traditional administration curricula. Using such a pragmatic perspective, it would appear that marketing would be expected to offer the following additions or differences:

A. Concepts:

1. Market positioning--the notion that the set of market relationships enjoyed or aspired to by the organization can be viewed both psychologically and "geographically" as representing a unique combination of products, prices and places offered to various market segments. This tends to bring with it the idea of distinct competitive advantage, emphasizing what the organization can do best for specific segments of the public, rather than responding to any and all needs or doing everything the organization is capable of doing.

2. Exchange relationships--the notion that relations between the organization and its public can be partly or even wholly understood in terms of quid pro quo, the exchange of values as perceived by each party to the exchange. This tends to include an emphasis on the psychological motivations of both parties rather than a focus on the obvious exchange of goods and services for money.

3. Behavioral engineering--the notion that some/most/all problems, threats and opportunities faced by the organization can be addressed in terms of understanding, predicting and influencing the behavior of individuals, groups and organizations. Using the concept of exchange relationships, performance of the organization can be assessed, planned and altered in terms of preventing or achieving changes in behavior of certain segments.

4. The marketing mix--the notion that exchange relationships can be understood, predicted and manipulated through modifications in one or more of the following:

   a) Product--the positive values, benefits or utilities derived by people engaging in exchange relations with the organization;
   b) Place--the extent to which it is easy or difficult to engage in such relations with the organization, both in absolute terms and relative to competing organizations;
   c) Price--the negative values, costs and unpleasant side effects of engaging in exchange relationships with the organization, relative to both the product offered and competing offerings of others; and
   d) Promotion--the media and messages used to communicate to potentially interested publics about the product/place/price offered by the organization, whose effectiveness is measured by impacts on behavior.

B. Techniques

1. Market Analysis--the collection and analysis of data in order to determine present behavior, attitudes and motivations of publics with whom the organization does or might engage in exchange relationships, intended to identify relatively promising vs. unpromising current market relations (e.g., portfolio analysis) or potential future relationships (market development). Such analysis is used to screen alternatives and select one or more for specific market development.

2. Market Dependence Analysis--the identification of responses by specific publics which must occur in order for existing or proposed market offerings/relationships to turn out successfully. This requires the identification of explicit success criteria, measures and objectives, subsequently translated into the behavior by identified publics upon which achievement of stated objectives depends.

3. Market Research--the collection and analysis of data used to design specific product/place/price/promotion attributes of a program so as to maximize its attraction to publics, given the expectations and limitations of the organization. Such research is used to design new programs or modify existing relationships so as to achieve marketing goals.

4. Persuasive Communications--the design and implementation of communication strategies intended to move specific markets through the hierarchy of effects: from unaware of the organization and its

exchange offering to aware, interested, determined and finally to active, even regular participation in exchange relationships.

None of these concepts or techniques is technically unique to marketing. Under different labels, all have, to some extent at least, been part of curricula in health services administration under rubrics already cited. Marketing tends to make them more explicit, and to apply them more consciously to assessing the present and shaping the future of the health services organization.

State of the Art--Present and Future

Marketing is only slowly and gradually, in a typically disjointed incrementalism, being adopted/adapted by health services organizations and being explicitly/implicitly taught by health services administration educational programs. There are essentially two approaches to both which seem to characterize current developments. In some cases traditional health and institutional planning is gradually absorbing marketing concepts and techniques and applying them to planning and management situations. In other cases, traditional marketing is gradually addressing the unique challenges and opportunities of the health services industry.

Much of the intitial focus of both effort and attention in marketing health services has been in the area of persuasive communication. This represents the most obvious and relatively unique aspect of marketing, at least as applied to health services consumers. Hospitals have always "marketed" to physicians, at least implicitly, under rubrics like physician recruitment and professional relations. Public relations has traditionally focused on the community, though not always explicitly as consumers and not always measuring effectiveness in terms of behavior. Early mentions of marketing efforts in the literature tended to focus on advertising of special packaging designed to entice people to prefer one health service organization over another, or to use preventive services not otherwise popular.

With the lack of large numbers of traditional marketing people familiar enough with health care, or traditional health care people familiar enough with marketing, much of early marketing was an extension of public relations, hence focused on communications or attractive amenities as devices for attracting consumers. These represented relatively modest and incremental changes to traditional health services, hence were largely non-threatening and easily cancellable if ineffective. The second phase of marketing, applying its concepts and techniques to the planning and management of health services from initial program design to implementation, has barely begun.

NOTE: As an indication of the order and speed with which marketing has been adopted by the health field, the first journal devoted to health marketing was essentially a public relations/advertising journal. The second, following three months later in publication, was devoted to traditional marketing. The third, following the second by only two weeks, incorporated both planning and marketing as applied to health care. All three are creatures of the 1980s, though whether all three will survive and prosper remains to be seen.

The future of marketing in the health services industry appears to be unlimited. It has been adopted much more quickly, thoroughly and enthusiastically than was planning, for example, and without the external threat of community agencies requiring it or threatening to do it for health care organizations as was true with planning. Its initial enthusiastic adoption appears to have arisen from a rather optimistic assessment of marketing's ability to turn unsuccessful organizations into overnight hits. Many health care organizations saw marketing as essentially a packaging and promotional device for attracting greater utilization of existing services. In so doing, they neglected two marketing realities:

1. If your product/place/price offering is not attractive, does not satisfy consumer expectations, or does not compete well with other existing offerings, packaging and promotion (especially as constrained by the unique ethics of the health industry) is unlikely to have dramatic effect.

2. Whatever potential effect promotional efforts might have, they are mitigated by promotional efforts your competitors are likely to engage in as soon as, right after, or even before you do.

Gradually, organizations are learning that marketing applies to initial decisions regarding what products/places/prices to offer which market segments, rather than to ways of overcoming mistakes in such decisions. Market research is being carried out more frequently, more thoroughly and more objectively by health organizations, often through use of outside market research firms. Product/place/price decisions are beginning to be made on the basis of market considerations rather than purely on the basis of professionally-defined need and financial considerations.

Marketing has long been applied on the fringes of health care in the development and especially the selling of pharmaceuticals and in health insurance (where I personally first encountered it). It has been enthusiastically if not always effectively adopted by HMOs, though not as early or thoroughly as might be expected (the Kaiser HMO of Portland, Oregon, and the Group Health Cooperative of Seattle, Washington, hired their first directors of marketing within the past two years, after decades of doing without).

Competition from HMOs using more overt marketing techniques, especially advertising, and more recently competition from their peers have virtually forced health care organizations to recognize the potential of marketing. The industry may be seen as following the same patterns of development as earlier industries but at an accelerated rate. It is likely that we will pass through the product-emphasis phase (focusing on packaging/advertising/selling) in a few years and enjoy the market-emphasis phase (focusing on designing offerings in response to understanding the motivations of the market) during the 1980s.

The prospect of deregulating the health care industry, or at least diminishing the anti-market effects of Certificate-of-Need and rate regulation, suggests that marketing is bound to become more important in the future. If a price-competitive system does replace the current product-competitive system (quality at all costs, cost-based reimbursement), the use of marketing will have to focus more on internal management decisions.

In order to be more price-competitive, health care organizations must be prepared to do a better job of controlling the use of as well as costs of specific services, and to make their investment decisions in light of the areas in which the marketplace, its consumers, and its competition will enable it to succeed.

Theory vs. Application

Marketing theory is deceptively simple. The idea that relations between an organization and specific individuals/groups or other organizations can be understood, predicted and influenced through exchange relationships is little more than common sense. On the other hand, it must be recognized that marketing is still an art rather than a science. Our understanding of human and/or organizational motivation is frighteningly inchoate at present, and predicting anything is fraught with uncertainty. Moreover, the success of one organization relative to a market is always going to be affected by what its competitors do, as well as by environmental changes and whatever the organization itself does. The best marketing team in the country dreamed up the Edsel.

Moreover, the field of marketing has thus far developed around essentially a profit motive and taken for granted a basically free, competitive marketplace. Significant modifications are necessary in order to adapt traditional marketing to health care. The organization is likely to be sensitive to a variety of motives or success criteria, of which financial health is but one. Meeting its sense of mission, being a leader, providing quality care, contributing to the health of the community, etc. are probably going to be important as well as "profit".

A "pure" marketing approach would have the philosophy: "Give the customers whatever they want and are ready/willing/able to pay for, as long as we can succeed by doing so." This is unlikely to be an acceptable philosophy for a health organization used to the mission of doing for people what is best for them whether they know it/want it or not. This product-oriented, paternalistic philosophy will probably never disappear, nor should it. Pandering to the whims of consumers even where it does no harm is an unacceptable basis for succeeding in health care. On the other hand, responding to their perceived needs and "educating" them into more reasonable wants fit well with both marketing and health services professional philosophies.

The health care marketplace is not a free, competitive market, nor is it likely to become one, whatever steps are taken in the future. Freedom of entry will continue to be controlled via licensing of professionals, reductions in federal support for training such professionals and Certificate-of-Need and rate control (to name but a few). Even if federal action eliminates national regulatory efforts, state and even local controls remain. Moreover, we are simply not prepared to yield control over what types and amounts of health care should be sold to consumers. We will probably see a slightly more competitive market for health care, but nothing like a true free market. Enthoven's proposals would create a kind of macro-market of health plans competing with each other for annual packages of health care insurance and provision, but this is far from a free micro-market of consumers shopping at will for health care as they see fit.

Marketing must be adapted to the unique opportunities and constraints which the health industry represents. Such an adaptation may occur best by starting with traditional marketing and learning through trial and error what adjustments are necessary. This has the advantage of offering all that marketing represents, but at the cost of numerous blunders in the learning process. Adaptation may better occur by incorporating useful marketing concepts and techniques in established health industry approaches to design and management of programs and organizations. This has the advantage of smoother sailing, but may miss out on opportunities to stretch the bounds of industry approaches because apparently unacceptable marketing concepts or techniques are rejected rather than tried. In a truly competitive situation both approaches should be tried; let the better one win. That seems to be exactly what's happening anyway.

## Issues

Aside from the question of which of these two approaches to adapting marketing to health care is superior, there remain a number of practical and ethical issues which should be addressed relative to incorporating marketing in health services administration curricula. Some of these are policy issues, subject to a priori discussion and resolution. More often, however, some research is needed in order to aid or even permit resolution.

Some a priori issues arise from the fact that marketing is a tool, a set of concepts and techniques which can be used (1) to further the interests of the organization, the public be damned; (2) to further the interests of the public, the organization be damned; or (3) to serve whatever the mix of these competing interests is deemed appropriate. It is clear that an organization must survive in order to serve any interests, though at a given point in time its demise may best serve the public's perceived interests better than competitors; hence survivors would be, by definition, serving public as well as organizational interests.

Yet history is sufficiently replete with examples of marketing being used to sell the sizzle without any steak. Fly-by-night HMOs in California, the development of me-too drugs--those with little true value (e.g., Panalba)--or even dangerous drugs (e.g., thalidomide) come to mind. In a marketplace where the individual receives the benefits but the community pays the cost, it will always be possible to attract consumers so as to "win" while disserving the public.

Such issues existed before marketing, but are raised to higher relief by the possibility that marketing concepts and techniques may stray from professional norms or even pervert them in the interests of prosperity. We know that individual professionals have strayed from the bounds of acceptable behavior in the interests of marketing success. What's to keep organizations from doing so if they learn better how to do it? Each organization and the communities served will simply have to deal with this issue as it applies. If marketing professionals claim any ethics, they will have to be especially careful in the health care industry.

Other a priori issues arise relative to the propriety of applying marketing at all, or certain of its concepts and techniques, to health care. Is not marketing essentially manipulating behavior? Yes it is, though the

argument would be that it only does so by making people better off for having modified their behavior. Is not market research essentially invasion of privacy? Yes it is, but the argument would be that participation is voluntary, and information gathered is used to identify so as to better respond to human needs and perceptions. Is not advertising essentially solicitation of business? Yes, it is likely to have that as its basic intent, but is justified as a way of making the public better informed as it makes choices and ultimately better served. Is not competition likely to produce excessive duplication of services and expensive failures? Yes, in the short run at least; but in the long run, so goes the argument, the public is best served by having only the fittest survive and prosper.

The propriety of marketing, even in a priori discussion, is likely to change over time based on its a posteriori effectiveness. Research is needed to answer at least three major questions:

1. When, why and how does marketing get incorporated into a health care organization and what is it used for?

2. What kinds of effects does marketing have on the organization's overall success, especially the differential impact on competing success criteria?

3. Are marketing activities cost-effective from the organization's viewpoint and from the community's?

We really are not prepared to answer any of these questions at present. We have some insights about when, how and why marketing gets employed, but nothing like empirical findings. We have no more than anecdotal evidence on the effects of marketing. As for cost-effectiveness, until it is financially sound for an organization to identify all efforts devoted to marketing as such given present third-party reimbursement prohibitions, this question cannot even be studied effectively.

## Curriculum Implications

The concepts and techniques of marketing clearly warrant inclusion in all health services administration curricula, if only because of their potential benefits (relying on experience from other industries) and potential harm (relying on some bad experience in health care). It is probably better to acquaint future professionals with their nature and potential value while guiding them toward its proper use than to hope they'll ignore it somehow. On the other hand, simply adding business school courses on marketing--even marketing of non-profit organizations--to health services administration curricula is probably not enough.

My own bias is toward incorporating marketing concepts and techniques into traditional health services coursework in planning and management. Separate coursework in market research techniques and persuasive communications may be justified, though social science research techniques and communications coursework may be acquired outside of business schools. If blessed with business school faculty who have successfully employed marketing in health care settings, health services administration programs should certainly make use of them. To merely send students off for a few courses in a marketing department, however, may do more harm than good.

There is no empirical research on the subject, and the author is certainly not an objective observer, but there is a fair amount of anecdotal evidence suggesting that people with straight marketing training tend to flop in health care organizations unless they learn a great deal about health care first. This suggests that marketing concepts and techniques ought to be identified and discussed in health services coursework, even if they are introduced and even pursued fairly extensively in marketing departments.

Marketing is a potentially useful tool for health services administrators, potentially valuable to their organizations and their communities. It is, however, only a tool, and to be used effectively by health services administrators it must be molded and shaped within the norms of the profession. Teachers of planning and management in health services education programs should become sufficiently acquainted with marketing to assist their students in the molding and shaping process. To ignore either marketing itself, or the necessity for adaptation as well as adoption, would be a disservice to students and to the public at large.

RESPONSE

by William A. Flexner, Dr.P.H.
President, Flexner & Associates
Minneapolis, Minnesota

Professor MacStravic's paper on a marketing curriculum for health services administration is a useful review of the concepts and techniques of marketing and their slow integration into the management of health care organizations. For those who are not familiar with what marketing adds to health care management, the first few pages of the paper provide an excellent overview.

Throughout the paper, MacStravic also describes many of the problems of introducing marketing into the curriculum--including concerns about "ethics" and the relatively limited experience on the part of faculty and practitioners with health care marketing. Implicit in MacStravic's paper is the potential misunderstanding among existing faculty of health administration programs that management on the basis of "designing and managing exchange relationships with important publics" (the definition of marketing cited by the author) is more risky, even potentially more unethical, than management on the basis of "doing for people what is best for them whether they know it/want it or not" (which the author correctly defines as a product-oriented, paternalistic philosophy of management).

This latter philosophy--one that emphasizes a "professional dominance" in the management of health care organizations--is referred to but never directly challenged in the paper. References to the philosophy include:

- "Marketing concepts and techniques may stray from professional norms or even pervert them in the interests of prosperity."
- "If marketing professionals claim any ethics, they will have to be especially careful in the health care industry" (emphasis added).
- Marketing "is, however, only a tool, and to be used effectively by health service administrators, [it] must be molded and shaped by the norms of the profession."

I suggest that in an environment in which consumer preferences and demands (those of the public, physicians, nurses, HMOs, businesses, and even the government) are changing rapidly, the teaching of this paternalistic, product-oriented, professional-dominated philosophy of management is not only more risky, but dangerous both for the student and for the organization in which the philosophy is maintained. Thus, in essence, I feel that Professor MacStravic's paper sets the stage for a lively discussion of the primary issue of this conference and of the function of a market-orientation in the health care organization: the training of health care managers to manage in a rapidly changing environment.

To assist in this discussion, I have chosen to concentrate my remarks on the "philosophy of management" that is taught in the health administration curriculum. First, I will attempt to describe in philosophical terms how the professional orientation that the students are exposed to in the health administration curriculum may inhibit management effectiveness. Second, I will focus on what I consider to be the fundamental difference between a marketing

philosophy of management and the traditional professional-dominated philosophy found in most health administration programs. And, finally, I will suggest some of the implications of this analysis for the transformation of our raw materials (students) into final products (managers) that will operate health care organizations effectively in the 1980s and beyond.

## Professional Dominance of Health Administration Curricula

Students who enter health administration programs often bring with them a value system that motivates them to do good for others--a sense of selflessness and altruism. Their purpose in seeking academic training is both to obtain the knowledge necessary to achieve their altruistic goals and to receive the credentials necessary to successfully enter and progress in their field.

As the students are exposed to the curriculum, however, their altruism is shaped by the faculty into a sense of professionalism--an expertise that legitimizes the actions that they will take in the name of their client populations. In developing this "we know best" management philosophy, a social arrogance is created in the students that is carried over to the programs that they will manage. Without realizing it directly, students who buy into the professionalism that dominates the curriculum are adopting a mind-set that will make them less effective at doing the "good" that they started out to do.

Here is why: health programs that are managed on the basis of a "we know best" social arrogance are created in the image of the expert professional and as such very often ignore the factors that motivate the consumers' behavior. The planning process used to create the programs is an inside-out approach that leads to ineffective programs or programs that are not as effective as they could be. Failure to produce effective programs--that is, to do the "good" that originally motivated the student to enter the health field--is a failure of the altruism that drives the health professional.

Although certainly not a panacea for redressing this dilemma facing health professionals and students, a market-oriented philosophy of management represents a set of concepts--a way of thinking--that permits the provider of a service to respond to consumers in ways that are more likely to produce a positive service transaction, in ways that are more likely to produce effective programs, in ways that are more likely to do "good". Given the rapid changes that are occurring in the health care environment, it is incumbent upon health administration faculty to develop ways to teach a different philosophy of management than is currently being taught. The traditional, professional-dominated management philosophy does a disservice to its students, to its clients (the organization that will hire them), and to their clients (the ones who use their services).

## Comparison of Philosophies of Management

The philosophy of management within any organization is best determined by the factors that influence the key decisions that are made. Internal organizational considerations, norms of professional peers, and marketplace demands all produce separate and often conflicting pressures on management decisions. The extent to which managers favor one set of pressures over the others largely defines the management philosophy that drives the organization.

Historically, the health care sector has been faced with greater demand than supply. In such a marketplace, management can largely ignore external forces and can successfully pick and choose those health services that it wants to produce. It can also base its decisions on what is desired by internal organizational forces or on what it defines as professionally acceptable. Thus, many health care organizations have defined themselves as serving the community's social needs, without ever actually going into the "community" to ask systematically what the people are looking for. In business, this type of philosophy is known as a production or product orientation and it assumes that "if we produce it, they will buy it." And, indeed, as long as demand exceeds supply, the assumption is largely correct.

Translated into a process of management decision-making, a product orientation takes the form largely of the inside-out flow mentioned above in which (1) a plan of action represented by mission statement, goals, and objectives is fashioned, largely based on internally-derived information and assumptions; then (2) strategies for bringing about these goals and objectives are developed, including the kinds of services to be offered, the location and price for offering the services, and the way to communicate to target audiences; and finally (3) the strategies are implemented by taking the service outside the organization into the marketplace. If management is lucky and has a pretty good feel for the marketplace, consumers will use what the organization is producing. In the past, health care organizations have often been able to get away with this type of management philosophy because of the excess demand for health services. With supply reaching equilibrium or even excess capacity in some areas, an inside-out planning process--particularly one in which professional opinions dominate the allocation of resources--will be increasingly risky.

A market-oriented planning process--what might be called an outside-in approach--is more responsive to these changing market conditions. In this process, management begins planning by looking outside the organization to the consumers and attempts to learn how they operate, what things are important to them, where they go for services, how they make their decisions to go to one place rather than another. Consumers are viewed in terms of subgroupings--or segments--based on similar behaviors and/or preferences. Each segment is then profiled according to identifiable characteristics. Included in this initial situational analysis is a consideration of both the internal capabilities of the organization and the preferences and size of the organization's current constituency.

Once the initial analysis is completed, the second step in the process is to develop a strategy for each segment of consumers. Only after consumers have been grouped into segments does management specify its operational goals and objectives and the means for achieving them through control of service design, location, price, and promotion strategies.

The two philosophies of management differ only in the timing of each step in the planning process. This difference, however, is <u>critical</u> for designing strategies that are sensitive to rapidly changing environmental conditions. Figures 1 and 2 attempt to show this critical difference in cartoon form. In Figure 1, the managers in the smoke-filled conference room are enthusiastically planning programs for the community needs. In the process, they have barred the windows and prevented important information from coming

to their attention--information that would greatly assist them in applying their limited resources in areas that represent the greatest likelihood of their services being successful. In Figure 2, the organization as a whole is tuned in to the changes that are occurring in the environment. Using this information, management is able to evaluate numerous alternative uses of its limited resources, including the option of cutting programs or services that do not work and entering areas that have traditionally been outside the normal scope of services offered by the organization.

Current trends and pressures--including the expansion of HMOs, consumer shopping for service alternatives, physicians seeking multiple hospital affiliations, the growing role of large businesses in the allocation of health care dollars, and the changes occurring at all levels of government--require a change from a traditional, professional-dominated philosophy of management to one that is more responsive to changes in the marketplace. A market-oriented philosophy of management starts with a focus outside the organization on the consumers, letting their preferences and needs guide the strategy of the organization. It is this philosophy that needs to permeate the curriculum of health services administration programs.

Developing a Market-Oriented Curriculum in Health Administration

Professor MacStravic concludes his paper by urging that health administration faculty do more than simply add marketing courses, particularly those run by business school faculty with no experience in the health care industry. He urges that "marketing concepts and techniques [be incorporated] into traditional health services coursework in planning and management." I agree. The managers of the future need to understand how to make critical decisions that are affected by market changes, financing, human resources, and the design of the organization, all in a complex health care environment.

Yet, herein lies a significant dilemma with regard to implementing this recommendation: Where are the faculty that can do this? The existing faculty of most health administration programs represent just the opposite philosophy of management. If this were not the case, the issue of two distinct philosophies would never have arisen. To achieve an entirely new curriculum, however, will require retooling on the part of the faculty members, as well as considerable external input to assist in this process of change.

Thus, the issue is not marketing courses *per se*, although at least one such course should be required of all students regardless of who teaches it. Rather, as emphasized previously, the issue is whether or not a curriculum that is responsive to the 1980s' management needs will be available for the new students of health administration.

Current faculty of health administration programs need to understand that the environment into which they are sending their students has changed dramatically from the 1950s, 1960s, and even the 1970s. They need to conduct their own "marketing audits" of that environment to determine what it is that real-world managers need from which appropriate coursework and curriculum philosophy can be developed. Completion of such an audit will reveal the critical need for a thorough awareness of the principles of marketing as they apply to management decision-making.

But it is not enough for just one faculty member to have this responsibility. All must be aware of the interrelatedness of the various disciplines being taught in the curriculum. Then, instead of just focusing on one's own discipline, each faculty member should be prepared to raise questions about the relationship between the discipline being taught and the others in the core curriculum. Finally, an effective market-oriented curriculum will require a "capstone" course that will integrate the management disciplines through a focus on organizational strategy and policy. Here, the students should be placed into managerial roles and forced to make decisions in the context of real-world management situations.

More than ever before, managers must learn to think and analyze before they make decisions and before they take action. Relevant thinking and analytical skills can be developed in an academic setting, if the academicians are sufficiently in touch with real-world problems. The programs in health administration that are successful in the coming decade will recognize this and make the necessary changes. The others may decline and be replaced by more innovative academic programs, often developed in the graduate schools of business administration.

Thus, it is decision time--and, to paraphrase Peter Drucker, the decisions made today affect the future of current academic programs.

FIGURE 1: AN INSIDE-OUT MANAGEMENT PHILOSOPHY

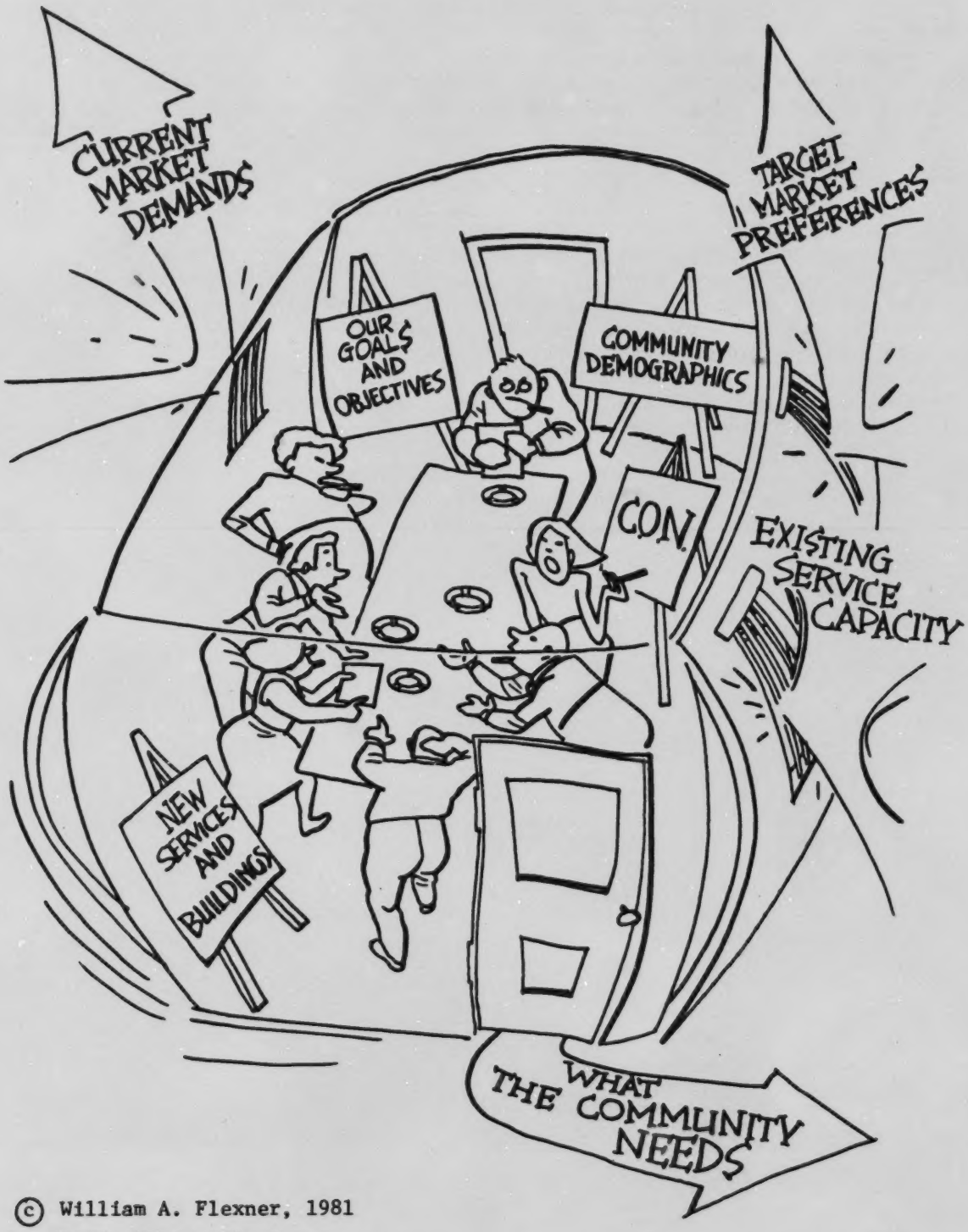


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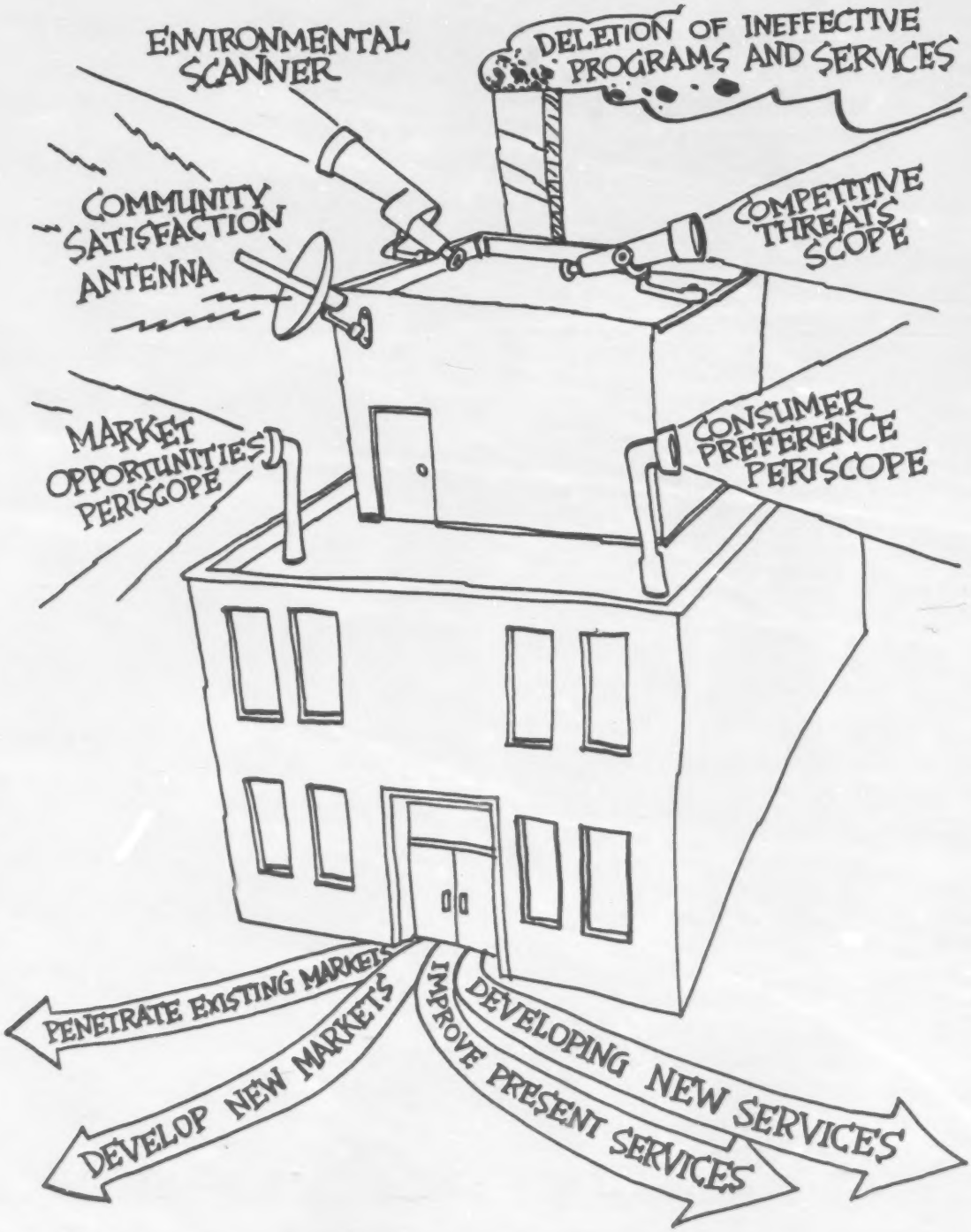
FIGURE 2: AN OUTSIDE-IN MANAGEMENT PHILOSOPHY

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RESPONSE

by Don C. Black, M.H.A.
Director
Regional Services
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It is not germane to our discussion of Dr. MacStravic's paper to debate whether or not there is a need for marketing in the health care field or whether it is ethical, moral or legal to engage in such marketing activities. Health care organizations have engaged in marketing since their inception, but not until recently have we been forced to re-evaluate and strengthen our marketing concepts in order to remain competitive in the environment.

I would like to review the following areas and will make specific comments on Dr. MacStravic's approach:

a. The current state of health care marketing,
b. Future role for health care marketing, and
c. Implications for curriculum.

Perceptions on the Current State of Marketing in the Field

We are all aware that health care marketing is perhaps the hottest new topic to enter the literature and practice of health care administration. There seem to be few health care managers with any significant training or background in the area of marketing. The masters programs in health care administration in general offer no input on marketing in their curriculum. Their health care management courses seem to be dictated by traditional and antiquated approaches to problem-solving for a system which is already a decade outdated.

Those organizations that have discovered a need for a marketing orientation have either chosen to develop internal personnel through the use of outside seminars and literature, or have selected marketing personnel from industry. This latter choice often includes those who have sales orientation and have had little experience in true marketing management. The problem is also magnified by those smaller organizations that must perform the marketing functions with little or no opportunity to develop staff or a sufficient skill base. There also seems to be a lack of qualified consultation from the outside with experience in the health care field to guide the different organizations in developing their own internal expertise.

In spite of these problems, many health care organizations have discovered the mystique of adding marketing to their organization. Marketing has been deemed the cure-all for the organization's problems. It can help you raise your census, improve your reputation, improve bad products, raise your ROI, and in general make the executive's job easier. Unfortunately, many of these cure-alls are discovered only in the literature and have very little application in the real world.

I would like to investigate just why we are in this current situation. Phil Cooper in Health Care Marketing--Issues and Trends (Aspen Systems Corp., 1979) has stated that there were essentially three sources for an organization's changing emphasis on the marketing concept:

a. Internal realization,
b. Consumerism, and
c. Governmental legislation.

Internal realization of the marketing concepts in most health care organizations is due to either a lack of knowledge or a lack of commitment to the marketing orientation. Most health care systems, hospitals or other organizations are headed by men of the Hamiltonian era of administration, in which the major emphasis was on developing the biggest and best institutions and thereby guaranteeing their success in achieving the organization's goals. This product orientation was in part due to the constraints leveled upon them by the boards of directors, medical staffs, publics and consumers. It is evident that the same forces that have caused business and industry to develop sophisticated marketing concepts will also motivate health care professionals to follow suit. As Dr. MacStravic pointed out, through the use and adaptation of marketing information from the business world we have developed adequate definitions of marketing and a base knowledge of specific techniques; however, we have failed to develop concepts involving the area of strategic health care marketing management. It is evident that one of the key areas for future curriculum development will evolve from strategic marketing management.

The second area then would be commitment to the marketing concepts. As I pointed out earlier, organizations have marketed since their inception or they would not have survived. Jim Rice from Health Central, Inc., has utilized a model for health care planning which includes an analysis of an organization's planner based on a competency model, and I believe this could be adapted to the typical health care marketer. In his view we can categorize planning from unconscious incompetence, to conscious incompetence, to unconscious competence, and finally--with some very select individuals--on the basis of conscious competency. It should be evident that up to now most organizations have marketed on the basis of unconscious competence. We have developed good products to meet the needs of our markets, especially when the markets in which we were participating were on the upswing of the product life-cycle. Given the current environment, however, we may now be entering the era when only conscious competency will truly guide our organizations. An adequate knowledge base and an organizational commitment will be the key toward achieving conscious competency in our future health care administrators.

This increase in internal realization of the health care marketing concepts must also be viewed in direct line with the increase in consumerism and the increase in government interest in the health care sector. A great many parallels can be drawn between the advent and explosion of the health planning fields five and ten years ago with the health care marketing opportunities of today. One also wonders whether the future and enterprising young legislator will not introduce a public law 99-641 entitled "The Marketing Law" which will force all health care institutions to develop a marketing orientation. I agree with Dr. MacStravic and his perception of the current state of marketing; however, we should again emphasize that health care marketing goes beyond the four walls of hospitals. The health care fields of long-term care, chiropractic and emergicenters and the various

organizations such as American Heart Association and Muscular Dystrophy have been extremely successful with recent marketing efforts. These have gone beyond mere promotional efforts to present clients and are now providing stiff competition to traditional providers. It may also become evident that at the present time the field of health care marketing involves the blind leading the blind toward an end that none of us can properly see.

## Future for Health Care Marketing

It is evident from changes in the field and from the nature of conferences such as this that the field of health care marketing should prosper in the decade of the 1980s. As new frontiers and new concepts are developed and refined for the health care industry, it will require further management expertise. As with most other health care fields, we tend to specialize and spin off new professions to fill any voids in employment; and with the ever increasing numbers of students graduating from programs in hospital administration, it seems realistic to feel that marketing will become a subset of the general field. I see two distinct trends emerging in the area of marketing:

1. Strategic marketing management will be incorporated into basic management, and
2. Health care marketing professionals will develop to fill the job market.

Today's health care manager is faced with the basic administrative needs involving finance, management, law, etc., and now must develop marketing orientation. He must be intimately familiar with the concepts of strategic planning, strategy formulation in a dynamic environment, development of strategic market plans, marketing analysis and market positioning and must incorporate these into his management repertoire. Dr. MacStravic has addressed the development of health care professionals who are skilled in specific marketing techniques. The concepts of marketing position, exchange relationships, marketing mix, the use of market analysis, etc., will be as familiar to these professionals as radiology rooms, medical staff bylaws and Medicare reimbursement is to the professional of today. We need as a marketing field to develop new data bases similar to the Pims Program, Data Line or other sources of information that are used in business and industry, as well as to call for additional refinement in the techniques of market analysis, market research and communications.

## Curriculum Needs

The implication for the university programs in health care administration should be quite evident. Health care marketing management must be taught as an integral part of the general management orientation. This could be accomplished by orienting the future administrator toward an overview of the essential aspects of the marketing management process and toward insights into the application of marketing disciplines to the management of health service organizations. This can be geared primarily toward the individual who will not be responsible for the marketing function, but will need to be aware of its functions in the same way as he is of financial management and nursing

service. Such a curriculum would offer the following objectives:

a. To broaden the administrator's understanding of the practice, history and philosophy of marketing;
b. To develop an understanding of the basic marketing skills and their application to a health care setting; and
c. To develop a good understanding of the elements of marketing management, strategic marketing management, product development, implementation and evaluation and their applicability within the health care field.

In addition to this overall management orientation, programs in health care administration should also provide curriculum for those interested in development of specific marketing skills applicable to the health care field. I would advocate the same overall curriculum as would be provided in a graduate school program in marketing, with specific emphasis and orientation to health care in the areas of market research, market audit, goals and objectives, market strategies, promotional activities, pricing strategies, makret positioning, etc. In addition, such courses could be developed around new product orientation and marketing application to a variety of health care organizations.

Conclusion

I enjoyed having the opportunity to review Dr. MacStravic's paper on a marketing curriculum for health care administration. I believe that the paper in general could serve as an excellent orientation to the academic needs of the health care marketer; however, it does not present concepts for development of curriculum in strategic marketing management which may in fact need to be developed before a marketing curriculum will be given the opportunity for development. In addition, I think Dr. MacStravic has concentrated too much of his efforts on traditional hospital activities and may not have considered in depth enough new markets that we are discovering in long-term care, wellness and the other by-products of health care such as pharmacies and health food restaurants. I would also differ with Dr. MacStravic in that I do not feel that major changes are necessary in adapting traditional marketing concepts to the health care field. It seems ill-advised to recommend that we try to change a successful system which has been operable in business and industry only to gear it to a health care system that in fact should adapt itself to business and industry.

The future for health care marketing curriculum in programs in health care administration must be seriously considered in light of today's environment. Marketing curriculum should be developed for the needs of the field in the future, not to respond to where we are today. There can be little question that the health care field in general and hospitals specifically have not been effective in even the most basic of marketing concepts, and that if we were to design a program of education that would fit the marketing practice of today we would already be a decade behind. We must look forward as educators to develop the health care system that we want, that we feel will best serve the needs of our publics, and then supply the education to challenge our administrators of the future. Phil Cooper has used the example of the fact that the Chinese word for crisis is made up of two characters: the first being danger and the second, opportunity. It is evident that our field of health

care in general and university programs specifically may be placed in this crisis situation unless we can reshape our markets to provide effective goods and services. We may clearly see those dangers on the horizon; yet we have the opportunity to react to those dangers by providing adequate education, research and information to the administrators of tomorrow.

DISCUSSION SUMMARY

by Morley deLashmutt-Robbins

After a diverse discussion regarding the theory, process and potential applications of health services marketing, conference discussion initially focused on whether health services should be regarded as a right or as a commodity to be "marketed" in much the same manner as automobiles and food are in this country. Professor MacStravic noted that until this century health services were very much a commodity. The notion that health services are a right is unique; however, he went on to ask whether providing certain health services to a population in need is the obligation of the individual organization or the community-at-large. The originator of this question concluded by stressing the fact that the issue of whether contribution is made to the poor or indigent is now a part of our national commitment, in large part due to the precedent set by the passage of the Medicare and Medicaid programs.

A point raised during the course of the presentations on the pervasive attitude of "professionalism" (i.e. we know what's best for you) resulted in a question of what approach should be employed in the teaching of future health services managers: should teaching focus on a market orientation or a professional attitude? In response to this issue Dr. Flexner noted the health services market is very complex due to pressures inside and outside the organization. An understanding of patients' and especially the public's health service needs is critical, yet historically hospitals have adopted a medical (professional) model. In addition, he stressed that market research is now showing the increased role patients are exercising in the decision to receive services. Consequently, Dr. Flexner concluded that "professionalism" is a dangerous attitude to foster and develop in today's graduates.

Discussion then went on to identify the fact that organizations external to hospitals are merely "media" for their own professionalism. The point was stressed that the influence of third-party payors is significant and cannot be ignored. Dr. Flexner concurred and reiterated that all the hospital's external influences must be studied and understood. He noted that an organization's market research could not be limited solely to the public's demands. In response to the question of who the market is for health services, it was stated that the market is any group, individually or in concert, which influences the program/service development within an organization. Nonetheless, there was considerable skepticism that services could be directly marketed to the public, due to the separation of consumers from the financing mechanism present in the health service sector. While he noted there were limitations to marketing directly to the public, Dr. Flexner again stressed the need to look in multiple directions--at more than one market--before the mission and program complements of an organization are defined. It was at this point that Dr. Bergwall called for a close to this discussion by recounting a favorite statement of Dr. Paul Samuelson's, that what was apparently being discussed was a "special case of the real world."

It was evident that the conference attendees felt the introduction of a market orientation in the health sector would not be accomplished without resistance or serious questioning of its legitimacy. In many respects, the

earlier questioning seemed to imply that marketing was akin to "hucksterism" as opposed to a management philosophy, in that there did not appear to be widespread belief that a market orientation could aid health service organizations in the design and execution of their commitment to the community or their service complement. As might be expected, many of the attendees of the program were blinded by the negative connotation associated with promotion (but one element in the marketing function) and what is commonly referred to as the "hard sell." It will only be as the public emerges as a significant purchaser of health services that this approach to management will be accepted, endorsed, and openly employed.

# INTEGRATING POLICY, PLANNING AND MARKETING IN THE CURRICULUM FOR HEALTH SERVICES ADMINISTRATION

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The thesis of this paper is that planning, policy and marketing as they relate to health and health services are inextricably intertwined.[1] It will demonstrate the relationships among these topics through a discussion focused primarily on planning. Then it will be suggested how these topics might be integrated within a graduate curriculum.

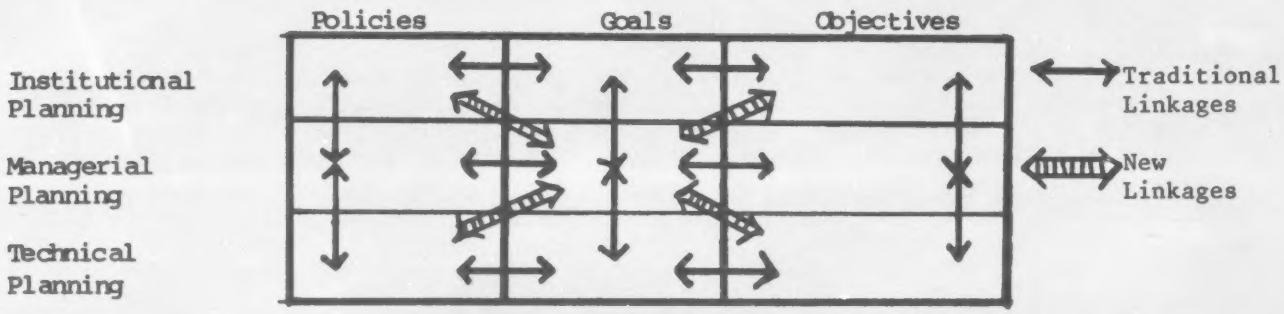
## Planning

Ackoff provides a useful classification of approaches to planning: inactive, reactive, preactive and interactive.[2] It is clear that strategic planning which is now perceived as the sine qua non of health services administration[3] falls into Ackoff's interactive class, which he defines as an effort to design a desirable future. Jantsch calls this futures creative planning and identifies three essential characteristics of such planning. Specifically, he asserts that futures creative planning must be: normative (value-directed), integrative (system-wide), and adaptive (cybernetic).[4]

It is true that, as Ackoff points out, there will be occasions when some other approaches to planning may be more appropriate; however, the skills and knowledge required for interactive planning should be adequate to allow the competent planner to meet the demands of any of the other approaches. In this connection, it is important to note that Ackoff's four approaches to planning do not represent types or levels of planning. Types of planning can be most usefully identified by using Talcott Parson's three levels of organizational structure: institutional/community, managerial, and technical.[5]

Each of these types of planning should reflect the characteristics enumerated above. This can be illustrated by an adaptation of a model originally developed by Lorange and Vancil.[6]

Figure 1: Modified Lorange-Vancil Model of the Strategic Planning Process



The model displays normative relationships in that policies (values) have a direct influence over goals and objectives within each level, and the policies of a higher level affect lower-level policies. It is cybernetic in that each stage of the process receives and adapts to information from adjacent stages. It is integrative in that there are both vertical and horizontal flows of influence and feedback. These traditional linkages reflect the situation in a closely linked organization with a clear hierarchy of power. Vancil and Lorange assert that in a decentralized organization with considerable autonomy at each level (as is true of many health services delivery situations), the diagonal relationships more accurately describe the plan development process. For instance, the policies of a multi-hospital system (institutional level) will be strongly influenced by the goals of member hospitals (managerial level).

Jantsch has on several occasions described the three tiers in greater depth and applied different labels to each level.[7] Figure 2 is an adaptation of Jantsch's models which incorporates Dror's[8] concepts of the components of policy. This figure will be the basis of further discussion of each of the three levels of planning.

Note also that the model is in effect a two-way matrix which reflects generic functions on the horizontal axis. Other authors suggest different functional sets, but there is general agreement that these generic functions are carried out at all levels of planning.

Policy (Institutional) Planning[9]

The purpose of policy planning is to create the institutions of the future. These new or revised institutions are reflections of society's values. To paraphrase Sir Geoffrey Vickers, policy regulates an institution over time in such a way as to optimize the realization of many conflicting values.[10] Thus, policies are operational statements of society's values. According to Dror there are three types of policy: Metapolicy, which is policy on policy-making; megapolicy, which expresses broad generic values; and policy, which is the focused application of megapolicy.[11] In the United States, for instance, we have:

1. metapolicies which set out the rules for establishing megapolicy and policy through legislative/regulatory/judicial processes,

2. megapolicy espousing free-enterprise capitalism, and

3. policies which govern our health services systems in a fashion that is more or less consistent with the free-enterprise model.

The normative nature of planning at this level is obvious. Policy planning is integrative to the extent that it recognizes and attempts to deal with conflicting values between population groups and among policy dimensions (i.e. conflict between economic policy and social policy). The cybernetic aspect of policy planning is reflected in the phases of the policy cycle.

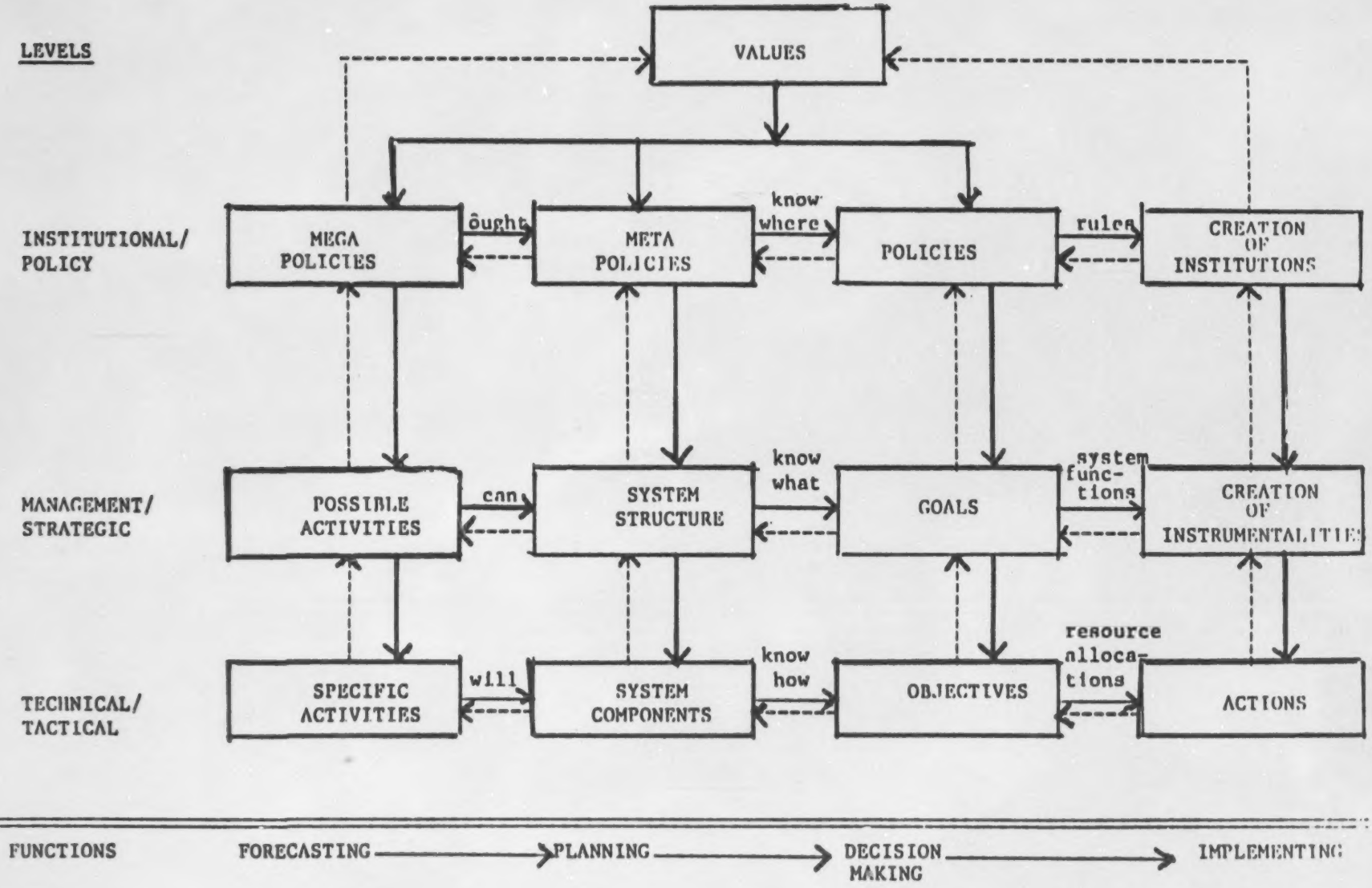
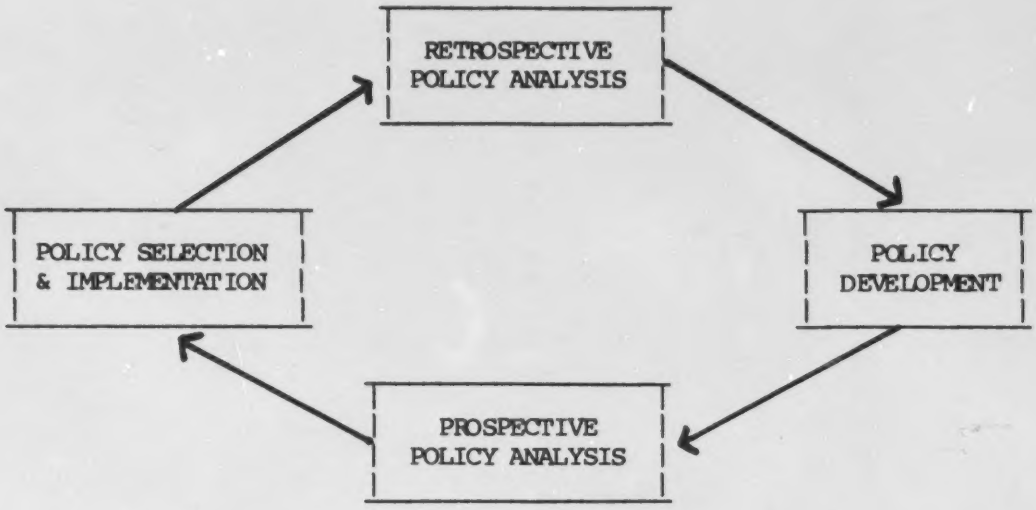



FIGURE 2: Planning Levels and Functions
(Adapted from Jantsch)

_____ Action
---------- Feedback

Figure 3: The Policy Cycle




This cycle might begin at the point of retrospective policy analysis, an examination of the completeness and adequacy of existing policies. Such an analysis will stimulate the development of policy to fill identified gaps or correct perceived deficiencies. The proposed policies are then subjected to prospective policy analysis which provides a basis for choice. It is important to note that implementability is a crucial factor in choosing among competing policy proposals; thus, a prospective policy analysis must incorporate the concepts of political science as well as the cost-benefit analyses (economic, social, political, etc.) which are included in retrospective policy analyses.[12]

The preceding description of the policy cycle should make it evident that all of the traditional policy concerns are encompassed by the scope of policy planning. The need to include this level of planning in instruction related to other levels of planning (i.e., the functions which have usually been designated as planning) is demonstrated by the relationship of policy planning and managerial or system planning. For instance, policy planning establishes the nature of the institution, which in turn dictates the configuration of the system (e.g., health services as an institution in which the judgement of individual members of one profession is always paramount cannot accommodate widespread development of systems which are similar to the institution of public education, in which there is considerable standardization and centralization of decision-making).

Managerial (Systems) Planning

Figure 2 indicates that the purpose of this level of planning is to create the instrumentalities which will perform the functions of the institution. Thus, managerial planning can be thought of as creating systems. Parson's definition, however, also justifies the use of the term 'systems' to indicate

a broad perspective with a concern for multiple aspects of the institution's performance.

Managerial planning is value-oriented in that it responds to the guidance of policy planning as shown in Figure 2. It is adaptive in that it relies heavily upon assessment of the environment for direction within the constraints set forth by policy. (Environmental assessment will be discussed more fully in connection with marketing.) It is integrative in that it seeks to attain an optimum balance among the components of the system. It differs from policy planning in that policy planning must generally seek to satisfice because of the qualitative nature of many of its analyses, while managerial planning has the tools and data which at least make optimizing a theoretical possibility. It differs from technical planning which, because of its narrow focus, seeks to maximize the output of a single component of the system.

To illustrate, megapolicy will determine the appropriate scope of health services as an institution. This might range from only medical care to the entire spectrum of health concerns implied by the World Health Organization definition of health. Megapolicy will also determine the amount of resources available for the institution. On the other hand, technical planning tends to be the province of specialists, each of whom is motivated (for good and sometimes self-serving reasons) to provide the public with as much as possible of their particular service and thus seeks to acquire as many resources as possible. The managerial planners must bridge the gap between the other levels. They must distribute the allocated resources so as to maximize the system's total output, and they may seek through the cybernetic process to obtain a larger allocation of resources for their institution. Unless they are successful, the future instrumentalities which are created will be congenitally malformed. For instance, because of the historical lack of systems planning, health promotion is markedly underdeveloped while medical care may be hypertrophic.

Technical Planning

This is where the action is. As Chairman Mao noted, there is no such thing as a "crossing-the-river" problem; there is a boat problem or a bridge problem. In other words, all of the abstraction of policy planning and managerial planning, no matter how sophisticated and elegant it may be, is of little value unless it leads to specific actions that will move the system and the institution toward the realization of their purposes. Fortunately, we understand quite well how to do the planning which leads to the accomplishment of specific tasks. The processes (e.g., budgeting) and techniques (e.g., PERT) have been developed and refined over many years. Unfortunately, much of our technical planning as currently practiced does not meet Jantsch's three criteria very well. It is often done with little regard for the institutional values (e.g., the Oral Roberts medical center). It is seldom based upon system-wide analyses (e.g., joint planning between independent acute and long-term care facilities). It is frequently not adaptive (e.g., continued maintenance of obstetric services in the face of declining utilization rates and population projections which predict even fewer fertile females in the service area).

There seems to be an increasing amount of planning activity within health services organizations (especially in relation to acute care in-patient services), but to date most of these efforts would fall into Ackoff's reactive category. Although they would not use these terms, leaders in the field now are striving to move their organizations into the preactive and interactive modes of planning. There are two commonly used terms for these efforts: "strategic planning" and "marketing".

Strategic planning is essentially what this paper has described up to this point. Marketing is a set of concepts and techniques which can be coupled with the traditional planning methods and with the policy analyses and development processes described above to provide the means to accomplish interactive planning.

Marketing

As MacStravic and others have pointed out, many people in the health services field hold a distorted view of marketing as little more than hard-sell promotional techniques.[13] Closer and more careful analysis of the marketing literature quickly dispels this misapprehension. For instance, any introductory marketing textbook describes a much broader range of activities and often identifies sets of generic functions that clearly relegate promotion/sales to a relatively minor role. One typical book lists six universal marketing functions and defines them in general terms to demonstrate their applicability to virtually any field of endeavor.[14] A shorter list, corresponding to MacStravic's "4 P's," can be used to show the relevance of marketing concepts at all three levels of planning. These functions, suggested by Lovelock[15], are: product, price, distribution (place), and communication (promotion).

Table 1 shows how each of these functions applies at each level of planning. Again MacStravic voices widely held concerns about ethical issues in the use of marketing techniques.[17] These issues reinforce Jantsch's assertion that effective planning must be normative, integrative and adaptive. In other words, the values expressed by the megapolicies and policies within the policy plan must guide and constrain the use of marketing techniques throughout the entire system, and these megapolicies must reflect the changing expectations of the environment (i.e., the general public). For instance, if the general public comes to accept the notion that health services delivery should be regarded as a competitive industry, the prevalent social service ethos (which is a significant segment of current megapolicy) will have to be replaced by the economic imperatives of commercial enterprises.

The preceding discussion has described planning in general terms and showed that a complete planning system will encompass both policy and marketing. Now it is time to consider another division that often appears in graduate curricula: i.e., community planning as contrasted to institutional planning.

Parsons made it clear that all three levels or types of activity existed for every organization, but that the locus of a level would vary among organizational types. For instance, policy planning for a private corporation is typically carried out by the board of directors and the social responsibility of such a firm is internally determined, while a public entity

Table 1: Examples of Planning Decisions Which Relate to Marketing Functions

| MARKETING FUNCTIONS | PLANNING LEVELS | | |
|---|---|---|---|
| | Policy | Managerial | Technical |
| Product | Definition of health (e.g., Is gun control included?) | Assessment of aggregate need/ demand for services (e.g., Obstetrics) | Determination of types of service (e.g., midwifery) |
| Price | What proportion of resources should be allocated to health services (e.g., percent of GNP) | Selection of methods of capital financing for health services | Determination of charges for individual services |
| Distribution | Level of trade-off between access and cost | Geographic locations for service delivery | Characteristics of health services facilities |
| Communication | Feedback from representatives of general community interest (e.g., elected officials or trustees) | Community health surveys[16] | Utilization data |

generally has the majority of its community responsibilities and its guiding principles mandated by legislative or executive branches of government or both.

Within the health services industry Steuhler's model shows clearly that all levels must exist within institutional plans.[18] Many authors, however, have noted the rapid increase in multi-institutional systems.[19] Zuckerman specifically points out how the locus of many responsibilities (especially policy-making) shift from the individual institutional level to the corporate (system) headquarters.

The probable demise of our current community health planning agencies (HSAs) can be attributed in large part to disputes over the loci of various levels of planning. There appears to be continuing widespread agreement that system-wide planning is needed at the local level; witness the many proposals to form "voluntary" planning bodies sponsored by business coalitions to fill the vacuum that will occur when HSAs disappear. HSAs lost much local support because they were compelled to emphasize the federally-imposed value of cost containment at the expense of the locally-espoused values of system improvement. Furthermore, HSAs encountered extreme hostility from providers as it became evident that they were developing narrowly-focused technical plans of great specificity in order to respond to mandates of federal regulations which emphasized cost containment and to the regulatory requirements imposed by Certificate-of-Need laws.[21] Parsons' predictions concerning such an invasion of technical planning "turf" by those responsible for managerial planning have, unhappily, proved to be all too correct.[22]

Nevertheless, despite the frequent misallocation of responsibility for various levels of planning, it is evident that all three levels are appropriate and necessary in both organizational and community planning. This confirms Breindel's assessment that the distinctions between micro and macro planning are largely mythical.[23] This is not to say, however, that planning functions are identical in all settings. Rather it means that the competent planner will be acquainted with both organizational and public-sector concerns and techniques (e.g., both corporate funds flow analysis and measurement of community tax and debt capacity).

## Curriculum Design

The preceding discussion led to a conclusion similar to those reached independently by each of the other four persons who were commissioned to prepare a paper for this conference. Specifically, the concepts of policy, planning and marketing are all inseparable components of an interactive planning process; they should not be studied as discrete, separate topics--particularly in circumstances which would not incorporate an effort to develop an appreciation of (if not a commitment to) the ethos of health services professions.[24] This paper, however, has emphasized a three-level planning system model into which the material of the other papers can be fitted. Table 2 recapitulates the major characteristics of each level and shows the disciplinary fields which are predominant at each level.

It is immediately apparent that no single graduate course could encompass all these topics at more than a uselessly superficial level; however, the

footnote to Table 2 suggest an alternate strategy which would be feasible. Specifically, one could develop course material which would introduce and emphasize the three core subjects (planning theory, marketing, information systems) and would also require the students to apply information derived from the other disciplines listed. Presumably much of this knowlege would be acquired during other courses in the curriculm; however, this would be an excellent point at which to apply Dr. Blum's concepts of learning how to learn, self-development and alternative learning environments. For example, it would not be unreasonable to expect a student without prior course work in public administration to learn how to prepare a legislative history as part of a realistically simulated policy analysis assignment.

Parenthetically, curriculum designers should pay special attention to Blum's advice to prepare students for an ill-defined future. This can be done in the ways he proposes and by stressing in each area of study the theoretical concepts which should be far more durable than current methods and techniques. Concrete applications and theory, however, must be included for two reasons. First, use of the theories seems to improve understanding and retention of the concepts. Second, although the long-range evolution of health planning may be unknown, there is also a short-range obligation to prepare students for employment at the end of their brief tenure in our programs.

Returning to the mainstream of this discussion, the faculty of The George Washington University's Health Services Administration program has found that the material described can be covered effectively in three semesters (one three-hour course each semester, which is roughly equivalent to four quarters at three hours per quarter). Each of the last two semesters involves a great deal of student participation in simulations. Presumably the same range of material could be covered in two semesters, if a different teaching approach (e.g., lecture only) were used.

Because of the three-semester sequence it has been convenient to emphasize one level of planning during each semester. Furthermore, instruction is designed to progress from technical planning through managerial planning to policy planning. The reasons for this sequence are:

1. Many of the techniques relevant to technical planning produce inputs for higher levels of planning (e.g., estimated need for a particular service is a factor in priority-setting at the managerial level).

2. Values and systems concepts alone are too abstract; the students need concrete points of reference for meaningful discussion and analysis (e.g., it is unlikely that a discussion of the relative merits of equal access and costs will be meaningful unless students know the reasons for the importance of access and the systemic implications of dispersal of service sites).

An alternative approach would be to divide the material on the basis of the four generic functions shown in Figure 2:

1. Forecasting,
2. Planning (including design of policies, systems and organizational components),

3. Decision-making, and
4. Implementing.

Although this is as diagramatically neat as the other proposal, it appears to have two weaknesses. First, students would not reach any point of closure in the process until they got to the implementing phase; by way of contrast, each of the three levels has a discernible end product. Second, it would be more difficult to deal concurrently with all the disciplines involved in all four levels (see Table 2) than it would be to discuss the application of a smaller number of related disciplines across the set of three functions.

To this point, the discussion has focused on a set of core courses for students who wish to specialize in the policy/planning/marketing aspects of health services administration. In doing so two major issues have been purposely overlooked: instruction in planning for non-planners, and instruction in specialized aspects of planning.

Just as those of us who are not mathematicians must know arithmetic, and generally find it advantageous to be familiar with the concepts of higher mathematics (e.g., understanding that marginal cost is the first derivative of the equation of a cost curve) so that we seek and evaluate the services of mathematicians when appropriate; so too the general manager and other administrative specialists must have some knowledge of planning. Since students' time and funds are both critical resources, the time devoted to acquiring this competence must be held to an essential minimum. This can be done by establishing a single required course for each individual who elects not to specialize in policy/planning/marketing. Ideally this should be a separate course specifically designed to provide a balanced coverage of all aspects of planning.

In the event such a course is not feasible, the next best alternative would be to require all students to take the first one of the sequence of planning courses. Although this course will emphasize certain aspects of planning, it must, as an introductory course, at least describe the other components of the planning process so that students can see the relationships between this course and subsequent courses; consequently, the non-planner participating in such a course will gain some knowledge of the entire process. In addition, this course will be the most useful to the non-planners since it will equip them to carry out small projects independently and to comprehend the work of planning specialists. Of course, a case can also be made for starting at the policy planning level. The support for such a decision might follow the analogous belief that a general manager must understand information systems concepts, but has no need to know how to interact with a computer.

At the opposite extreme are the needs of those students who wish to study specialized aspects or applications of the planning process. Topics of interest might include development of national health policy, policy issues in aging, ethics in health services administration, health resources allocation policies, etc. These illustrations suggest the diversity of student interests, which in turn implies a potential problem in having classes large enough to be educationally sound and economically viable. In most graduate programs the number of planners is not likely to be large enough to meet the class size criterion if more than one or two specialties are offered. There

are two ways this constraint can be removed, and fortunately they are not mutually exclusive. The most common is to allow students, individually or in small groups, to do independent study or research projects with individual faculty members who have competence in an area of mutual interest.

The alternative is to design specialty courses in such a way that non-planners can participate successfully. This is not a task to be undertaken lightly. It obligates the teacher to create a situation in which the planning students are not subjected to redundant instruction and in which the non-planners are not required to accomplish work for which they have not been prepared. Obviously, there will be few cases in which the instructor can fully achieve both of these goals; the usual solution is to seek a balance which is more less acceptable to both groups. A more creative and perhaps riskier approach is to design learning situations in which the planners become responsible for bringing the non-planners to an acceptable level of competence in the necessary procedures and concepts. The phenomenon of the teacher learning during the process of instruction is well known. By applying it in these circumstances, we can create a "win-win" situation, since both groups would be learning the necessary "redundant" material (albeit at different levels).

Table 2: Major Characteristics and Predominant Disciplines of Planning Levels

PLANNING LEVELS

| | POLICY | MANAGERIAL | TECHNICAL |
|---|---|---|---|
| Purpose | Creation of Institutions | Development of Instrumental Systems | Accomplishments of Actions |
| Approach to Goal Attainment | Idealizing Satisficing | Optimizing | Maximizing |
| Planning Mode | Normative | Allocative | Administrative |
| Nature of Content | General | Moderately Specific | Detailed |
| Orientation of Decision-Makers | General Community Interest | Health Services Generalist | Health Services Specialist |
| Predominant Disciplines* | Public Administration, Political Science, Ecology | Interorganizational Behavior, Economics, Systems Analysis, Epidemiology | Administrative Theory, Behavioral Science, Industrial Engineering |

*Does not include planning theory, marketing and information systems which are of major significance at all three levels24

Summary

There appears to be a widespread consensus that there are three levels of planning, each of which includes a similar set of functions. An analysis of the planning system in terms of the cells of a level/functions matrix reveals that such a system would encompass all of the major elements of the fields addressed by this conference (policy, planning, marketing) as well as information systems. Further analysis indicate that all planning programs included, explicitly or implicitly, all cells of the matrix. Consequently, it would be unwise to design courses which seek to deal exclusively with planning as it relates to a single setting (e.g., institutional).

Because of the interrelatedness of the topics, it was recommended that they should all be taught within a series of courses focused on health planning systems. The portions of these courses requiring application of the core disciplines should also be designed to incorporate the use of concepts and technqieus derived from supporting disciplines (e.g., economics, political science) which are not included in the formal instruction component of these courses. There are a number of bases for dividing the material among the courses in the proposed sequence; however, there appear to be some distinct advantages to organizing course material on the basis of the three planning levels and progressing from the rather specific technical level to the more abstract policy level.

FOOTNOTES

1. This point of view is generally consistent with the position taken by the Health Planning/Policy Task Force of the Accrediting Commission on Education for Health Services Administration (ACEHSA); however, that group did not consider marketing as a separate area or discipline. See "Report of the Health Planning/Policy Task Force of ACEHSA - Part I" in AUPHA Program Notes, Vol. 193, March/April 1981, pp 21-36.

2. Russell L. Ackoff, Redesigning the Future (New York: John Wiley and Sons, 1974) pp 22-31.

3. Carl W. Thieme, Thomas E. Wilson and Dane M. Long, "Strategic Planning for Hospitals Under Regulation," Health Care Management Review, Vol. 6, No. 4, Spring 1981, pp 35-43, Peter A. Nottonson, "Master Planning--Key to Survival," Osteopathic Hospitals, Vol. 25, No. 16, June 1981, pp 8-11; Kenneth M. Jones, Jr., "Long-Range Strategic Financial Planning", Topics in Health Care Financing, Vol. 7, No. 4, Summer 1981, pp 23-29.

4. Erich Jantsch, Technological Planning and Social Futures (New York: John Wiley and Sons, 1972) pp 138-139.

5. Talcott Parsons, Structure and Process in Modern Societies (Glencoe, IL: Free Press, 1970) pp 59-69.

6. C. P. McLaughlin, C.M.C. Smythe, P.W. Butler and A.B. Jones, Strategic Planning and the Control Processes at Academic Medical Centers (Washington, D.C.: Association of American Medical Colleges, June 1979) pp 27.

7. Jantsch, op. cit., p 16 and "From Forecasting and Planning to Policy Sciences," Policy Science, Vol. 1, No. 1, Spring 1970, pp 31-47.

8. Yehezkel Dror, Design for Policy Sciences (New York: American Elsevier, 1971).

9. The term "institutional" as used by Parsons and Jantsch refers to social institutions (e.g., education, religion). Since, however, in health services jargon institutional planning is the term regularly used to denote facility or single organizational planning, I will use the term policy planning in the remainder of this paper.

10. Sir Geoffrey Vickers, Freedom in a Rocking Boat: Changing Values in an Unstable Society (London: Penguin Press, 1970).

11. Dror, op. cit.

12. The stages in the policy cycle were developed from ideas presented in Helen Abrams, and Cyril Roseman, State Health Policy Analysis (Denver, CO: PACT, 1978).

13. R. E. McStravic, "Marketing Curriculum for Health Services Administration," paper prepared for GWU/AUPHA/ASHP Conference on Curriculum in Policy, Planning and Marketing, August 1981; Terrence J. Rynne, "The Third Stage of Hospital Long-Range Planning: The Marketing Approach", Health Care Management Review, Vol. 5, No. 3, Summer 1980, pp 7-15.

14. William G. Nickels, Marketing Principles (Englewood Cliffs, NJ: Printice-Hall, 1978) pp 33-43.

    1. Market Analysis - learning about supply of and demand for goods or services.
    2. Marketing Communication - conducting multi-directional exchanges of information between providers and consumers.
    3. Product Differentiation - adjusting product offers of both consumers and providers so that a mutually beneficial exchange can occur (includes product design).
    4. Market Segmentation - identifying most likely consumers of products offered by providers.
    5. Valuation - making cost-benefit analysis of potential exchanges to determine if both consumers and providers will participate in the transfer of benefits between parties.
    6. Exchange - facilitating the transfer of benefits between parties in marketing relationship.

15. Christopher H. Lovelock, "Concepts and Strategies for Health Marketers", Hospital and Health Services Administration, Vol. 22, No. 4, Fall 1977, pp 50-62.

16. Roberta N. Clarke, and Linda Shyavitz, "Marketing information and Market Research - Valuable Tools for Managers", Health Care Management Review, Vol. 6, No. 1, Winter 1981, pp 73-77 offers an interesting distinction between special studies and the use of routine operating data which clearly demonstrates that health services administrators have been applying marketing techniques, although under different names, as part of their planning process for many years.

17. MacStravic, op. cit., pp 8, 110-11.

18. George Steuhler, Jr., "A Model for Planning in Health Institutions", Hospital and Health Services Administration, Vol. 23, No. 3, Summer 1978, pp 6-27.

19. M. Orry Jacobs, "Cooperative Planning," Hospitals and Health Services Administration, Vol. 25, No. 4, Fall 1980, pp 23-35 is one example.

20. Howard S. Zuckerman, "Multi-Institutional Systems: Promise and Performance", Inquiry, Vol. 16, No. 4, Winter 1979, pp 308-309.

21. Gordon D. Brown, "HSAs, and Hospitals: Counter-Planning Strategies," Hospitals and Health Services Administration, Vol. 23, No. 4, Fall 1978, pp 65-74.

22. Parsons, op. cit., p 64.

23. Charles L. Breindel, "The Myth of Micro and Macro Health Planning" Hospital and Health Services Administration, Vol. 25, Special #1, 1980, pp 38-47.

24. Although it was not discussed in the text, it seems self-evident that information systems must be a major factor in all three levels in order to permit the planning system to meet Ackoff's requirement of adaptiveness (cybernetic capacity).

DISCUSSION SUMMARY

by Ann Zuvekas

The relationship between planning and management, both for curriculum and for career patterns, was the focus of much of the discussion. The group agreed that is undesirable and unlikely that any health administrator should spend his or her career exclusively in planning or management, but rather that most will zigzag between staff and line responsibilities. Most will not enter policy positions until five to ten years after graduation. This zigzag career path may require attitudinal changes for everyone, including faculty and employers, as well as practical considerations such as portability of benefits.

A curriculum in "planning" thus becomes a misnomer. Schools must be about the business of training generalists in health services management with specialist skills. That is, students' education must be general enough to permit their growth in an unknown future (e.g., learning how to learn) while permitting acquisition of skills attractive to first employers. It thus follows that skills in planning and marketing can be taught in two contexts: (1) as an integral part of a core curriculum in health administration, and (2) as special supplemental courses.

These special planning courses might be the three-semester sequence from technical (program) to policy planning, as discussed in Dr. Reeves' paper. This gives students competence in specialty skills early in the educational experience, then proceeds to the more abstract. Some participants feared that beginning with the technical would lead students to the wrong expectation: that they could then apply the mathematical purity of, for example, Operations Research to value-laden policy questions.

Marketing as a subject could also be presented both in the core health administration curriculum and as a special subject. Participants differed over the desirability of teaching marketing within the health administration department vs. sending students to the business school for this training. Those who preferred teaching marketing within a health administration context argued that health institutions must be responsive to all their "stakeholders", while other corporations are responsible only to their stockholders. That is, health care must contain an ethical component which may be lacking in other industries. Those participants who preferred teaching marketing within the business school cited traditional health administration inexperience and even hostility to marketing health care, pointing out that health care facilities are both social institutions and businesses. They decried the "professional knows best" bias implicit in the assumption that health is heavily normative. All agreed that health administration faculty need to be reoriented away from their biases against business, perhaps through seminars with informative and charismatic leaders such as Ackoff.

Also related to the generalist/specialist question is whether to teach students to manage or to do. For example, all health administrators need to be able to manage a Management Information System, but do they need to be able to design, program, modify, etc., a MIS? Similarly, both administrators and planners need an understanding of institutional finance, but to what extent? The answer seems to be that students must have sufficient acquaintance with

all subject areas, including such value-laden subjects as medical ethics, to be effective long-term generalists, while demonstrating more developed skills in one or more areas attractive to potential employers.

These general and specific skills may be gained in both a didactic setting and practical fieldwork. Dr. Reeves expressed his preference for giving students a strong didactic experience first, followed by fieldwork, especially for those students without previous practical experience. He noted that students who are aware of their education's direct and opportunity costs may prefer more emphasis on didactics.

Throughout the discussion participants emphasized the "real world" of departments of health administration: limited faculty, high costs of curriculum modification, limited space in the curriculum, and the difficulties involved for all in accepting dramatic change. The discussion closed with two general points:

(1) The strength gained by diversity among health administration programs must be maintained; and
(2) Learning does not stop when the degree is granted, for the program is not an entity but a process.

PAPERS FROM CONFERENCE II - APRIL 1982

# INTRODUCTION

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At the 1980 AUPHA Annual Meeting, planning and marketing faculty from several member programs came together for the first time to discuss issues of curricula design and development in the areas of planning and marketing. Over the two-year period since the development of this faculty group, a number of meetings and exchanges of information have occurred culminating in a major two-day curriculum workshop in August 1981. Out of that workshop came recognition of the need for in-depth discussion of curricula for strategic institutional planning.

The session, held during the final day of AUPHA's 1982 Annual Meeting, was designed to allow faculty to present and discuss illustrative instructional modules related to three phases of the strategic planning process: value determination, plan development, and plan implementation. These modules were designed to demonstrate different disciplinary approaches to strategic planning, course content, and specific teaching methods and techniques. This session was organized as a collaborate effort of the Society of Hospital Planning of the American Hospital Association and of AUPHA. Session organizers were Barbara Arrington, St. Louis University; Ken Bopp, University of Missouri; and Philip Reeves, George Washington University. The session was attended by over thirty-five individuals representing program planning and marketing faculty and practitioners.

## Value Determination

David E. Berry, Dr.P.H. (University of Kentucky Medical Center) presented a paper entitled "Problem Definitions and the Strategic Planning Process for Hospital and Health Service Organizations." Dr. Berry stated the belief that values form the beginning point for plan development and plan implementation in the strategic planning process. As strategic planning in health care institutions enters the 1980s, concern for trade-offs between competing values such as access and cost containment are of paramount importance. Dr. Berry focused his discussion on problem definition as the essential component of value determination. Defining problems and arriving at goals and objectives, which are required for plan development and implementation, is essentially value-based. Values form the basis on which conditions in the environment are determined to be undesirable. Problem definition has two major dimensions: a substantive dimension which deals with competing values and a process dimension which is concerned with governance and methodology. Dr. Berry used a conceptual framework developed by T.J. Cartwright in the article "Problems, Solutions, and Strategies: A Contribution to the Theory and Practice of Planning" (Journal of the American Institute of Planning, May 1973, pp 178-187) as the basis for his curricular recommendations. This typology describes problems as being of four types: simple, compound, complex, and metaproblems. Dr. Berry then provided several examples illustrating the use

of Cartwright's typology in demonstrating the impact of values on problem definition. Illustrations may also be used to show the benefits of analysis of a problem at various levels of an organization. Problem definitions may complement each other, compete, or substitute for each other. The typology can help to illustrate the sequencing of problem definition and the hospital's interface with its environment.

Value clarification and determination is an extremely difficult but necessary first step in the strategic planning process. Using a problem definition approach may help to provide a more systematic process for consideration of values in the strategic planning process.

Andrew Lasser (University of Missouri) and Scott Mason, D.P.A. (National Health Advisors Ltd.) responded to Dr. Berry's paper. Both respondents agreed that values determination and clarification is an essential initial and ongoing part of the strategic planning process. Dr. Mason stressed the difficulty of this in actual practice and the necessity for encouraging values congruence throughout the planning process. Mr. Lasser added that value determination is equally important in the environmental scanning and boundary spanning activities of hospital executives. Value determination was seen as an important concept to develop in curricula offered in graduate programs in hospital and health care administration. Complex and turbulent environments require decision-making skills which intertwine problem definition skills with an appreciation for the need to adapt to changing values in environmental conditions.

Plan Development

Roberta N. Clarke, D.B.A. (Boston University) provided suggestions for curricular design and development in the area of strategic plan development. Stressing a managerial approach to strategic planning, Dr. Clarke suggested that plan development curriculum must stress: recognition and analysis of all factors affecting the organization; prediction of how and how much each of these factors will affect the organization; and development of a coherent strategy which will address all these factors so as to maximize the success of an organization. In terms of curriculum content, Dr. Clarke stressed the current emphasis in strategic planning on marketing and formulation of marketing strategy. While relying heavily on marketing and management policy courses, the responsibility for strategic planning education lies throughout the curriculum, including course work in finance, accounting, economics, operations management, and organizational behavior.

Dr. Clarke suggested a number of text books which are particularly helpful in the area of corporate strategic theory, as well as a basic framework for the teaching of strategic planning based on the work of Philip Kotler. Organization size, organization resources, organizational leadership and organizational constraints all are important considerations in strategic plan development and should be discussed as part of a curriculum in this area. Environmental analysis, resource analysis, objectives and goal formulation, strategy formulation, structure and organizational design, and systems design are areas of skill which must be developed, either in a specific course, or preferably throughout the management curriculum.

Teaching approaches should differ based on the concepts being taught. Theory of strategic planning is best taught through traditional use of text books, articles and lectures. The case approach for more active hands-on learning is essential to an understanding of the process of developing a strategic plan. Presentation of theory and application through casework provides students the opportunity to apply theory to real life situations and to develop skills in strategy formulation.

While formulation of a specific strategy planning module is probably appropriate, it is important to include strategic thinking as an integral part of the curriculum across all managerial functions. The two functions likeliest to claim formal rights to strategic planning curriculum design and development are most likely marketing and management policy.

Don Harris (Fairfax Hospital Association) and George Stuehler, Sc.D. (University of Maryland) applauded Dr. Clarke's emphasis on integration of strategic thinking throughout a management curriculum. Both Mr. Harris and Dr. Stuehler re-emphasized the need for practical exposure and applauded intensive use of cases for teaching purposes. Dr. Stuehler expressed the belief that there is support by the field for integration of finance and managerial policy into strategic planning curriculum. Reporting on a cursory review of employment opportunities for strategic planners in health settings, Dr. Stuehler found an increasing emphasis on financial and managerial decision-making abilities in institutional planner job descriptions.

Plan Implementation

Robert Myrtle, D.P.A. (University of Southern California) presented curricula recommendations in the area of plan implementation. Dr. Myrtle stressed the importance of viewing planning and implementation as a continuum and not as separate activities. Providing students with this orientation requires an open systems view of the planning-implementing cycle emphasizing intra- and interorganizational processes for change. To this end, curricula relating to plan implementation should include the following elements of the planning process: legal requirements, organizational change, organization and processes for planning, service area determination, medical staff analysis, program analyses, community analyses, impact assessments, mission, role, goal and objective development, program development, facilities planning, financial analysis, Certificate-of-Need requirements, implementation management, and marketing as an implementation strategy. Viewing plan implementation as centered on deliberately managed organizational change requires emphasis on the process aspects of plan implementation in the curriculum. Emphasis is also placed on developing sensititivity in the students to the influence that power and politics have on an organization and its ability to adapt.

Dr. Myrtle emphasized the importance of interacting theory and practical applications in the design of the curriculum, as did Dr. Clarke. Dr. Myrtle also suggested regular involvement of planners, consultants, and other strategic planning practitioners to comment on and react to student efforts. Organization and management of the planning process should be emphasized as major contributors to plan implementation.

Two areas needing further exploration for curricular development were identified by Dr. Myrtle. The first of these was the need to perhaps develop

a more generic set of planning concepts which takes the concept of institutional planning beyond hospital walls and considers other settings such as ambulatory care settings. Secondly, the concept of strategic positioning vis-a-vis other providers in the environment needs to be addressed.

Douglas R. Brown, Ph.D. (Cornell University) and Martin B. Gerowitz, Ph.D. (Xavier University) responded to Dr. Myrtle's paper. Both agreed with Dr. Myrtle on the importance of the development of political sensitivity in strategic planning curricula. Brief scenarios, cases and other frequent hands-on experiences in and out of the classroom were seen as important curricular aspects for plan implementation. Evaluation as a component of the curriculum for plan implementation was also stressed.

# PROBLEM DEFINITIONS AND THE STRATEGIC PLANNING PROCESS FOR HOSPITAL AND HEALTH SERVICES ORGANIZATIONS

by David E. Berry, Dr.P.H.
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Clear and stable values form the building blocks for plan development and plan implementation in the strategic planning process. For example, the major concern of the 1980s is cost containment, and efficiency is an important value acknowledged by health planners, administrators, regulators, and the public. Competing values, however, such as access, quality of care, comprehensive services and continuity of care also deserve systematic attention. Strategic planning in the 1980s is seriously concerned with these trade-offs. Otherwise we face the "efficiency threat" expressed by the philosopher Bertrand Russell:

> I think certainly where bad actions are concerned the more inefficient the better. Such is human nature--or such has it been hitherto--that there are a great many bad actions which people are anxious to perform efficiently. I think man might say that the human race has survived owing to inefficiency but inefficiency is diminishing and therefore the human race is threatened with extinction.*

The general subject of this paper is value determination as a part of strategic planning. The specific focus will be on problem definition as a fundamental component of value determination. In order to establish the context for this discussion, both the terms strategic planning and value determination require further clarification since a consensus on their meanings has not been reached.

Strategic planning, in this discussion, refers to planning which involves a moderate to long range of time in contrast to short-range, tactical planning including budgeting. Strategic planning may form the framework for tactical planning and their boundaries are frequently not distinct. Program planning, a term commonly used in the health field, and physical planning do not always fall neatly into either category except as they may be performed in a specific situation.

As an ideal, strategic planning includes a way of thinking that requires problems and opportunities to be examined within both organizational and environmental contexts. Strategic planning may occur in a single organization, such as a voluntary non-profit hospital; in a corporation, such as a for-profit hospital system; or as an inter-organizational process in one

*In Bertrand Russell Speaks His Mind (New York: Avon Book Division - the Hearst Corporation, 1960) p 65.

or several communities. Strategic planning is future-oriented and ideally grounded in an understanding of history and existing constraints. The process for strategic planning varies significantly by problems or opportunities. Ideal strategic planning and the practice of strategic planning vary considerably. The health sector has had minimal success with strategic planning. Interest in this area has evolved in the recent past as a counter planning strategy by hospitals against federally-mandated planning and increased competition among hospitals. The growth of for-profit and non-profit multi-hospital systems has brought an increased positive potential for strategic planning.

Value determination is part of the process of defining problems and arriving at goals and objectives required for plan development and plan implementation. Value determination also overlaps and provides an important dimension to plan development and plan implementation (Charts II and III).

VALUE DETERMINATION AS A COMPONENT OF STRATEGIC PLANNING INCLUDES:

- DEFINING PROBLEMS.
- ESTABLISHING GOALS AND OBJECTIVES.
- IDENTIFYING CLOSE RELATIONSHIPS BETWEEN FACTS AND VALUES IN DATA ANALYSES.
- IDENTIFYING IMPLICIT AND EXPLICIT VALUES IN ACTION STRATEGIES.
- IDENTIFYING CRITERIA AND ASSUMPTIONS IN EVALUATING THE SUCCESS OF A PLANNING ENDEAVOR.

VALUE DETERMINATION IS AN INTEGRAL PART OF STRATEGIC PLANNING.

VALUE
DETERMINATION

PLAN
DEVELOPMENT

PLAN
IMPLEMENTATION

Problem definition is a central focus of value determination. Conditions exist in the world; and when an attribute is labeled as undesirable, the condition is defined as a problem. Problems are not objective realities but are perceptions based on the values, knowledge, and skills of the analyst. For example, cost containment was defined by the Carter Administration as primarily a problem resulting from the intense competition among hospitals for equipment and facilities. Their proposals focused on controlling supply through planning and regulation. The problem has been redefined with a new administration, and the behavior of employers and consumers are major concerns. Increased demand for health services is associated with fringe benefits, income, education, and improved efficacy of care. Proposals which shift the burden for insurance directly to the consumer are receiving serious attention. Proposals to increase competition among hospitals based on price are also being considered by government and industry.

Problem definition may be conceptualized as having two major dimensions, a substantive dimension which deals with multiple and sometimes competing values and a process dimension which is concerned with governance and methodology.

PROBLEM DEFINITION

1. SUBSTANTIVE—E.G., ACCESS, CONTINUITY, QUALITY, AND EFFICIENCY

2. PROCESS
   A. GOVERNANCE - A WAY OF DECIDING:
      WHO DEFINES PROBLEMS?
      WHAT ARE THE RULES?

   B. METHODOLOGY

      1. CONCEPTUALLY - A WAY OF THINKING ABOUT INTER-RELATIONSHIP AND IMPORTANCE

      2. DATA ANALYSES - A WAY OF EXPRESSING QUANTITATIVELY RELATIONSHIPS AND IMPORTANCE

This paper specifically addresses the issue of problem definition by considering the transfer of a conceptual framework, developed by T.J. Cartwright in the article "Problems, Solutions and Strategies: A Contribution to the Theory and Practice of Planning" (Journal of the American Institute of Planning, May 1973, pp 179-187). He summarizes his thesis as follows: "... the nature of a problem governs both the range of possible solutions to the problem and the kinds of strategies appropriate for achievement of those solutions." (page 178)

A typology of problems was developed by Cartwright which seems particularly useful as part of the process of teaching strategic planning. Cartwright considers a problem to have two basic components: the number of variables included in the definition of a problem, and the precision of specifications of the components. The variables associated with a problem may be specified or be open-ended. These variables may be calculable or incalculable. The number of variables and their specifications are used to express four types of problems:

CARTWRIGHT'S TYPOLOGY OF PROBLEMS*

I. Simple Problems - a specified number of calculable variables. (Simple does not mean easy to solve.)

II. Compound Problems - some of the variables may be specified and calculable (as is true with simple), others may be open-ended.

III. Complex Problems - number of variables may be specified (a feature common with compound) but the variables are incalculable.

IV. Metaproblems - least precisely defined problems. The numbers of variables are not specified and those acknowledged are not calculable. A metaproblem acknowledges that unsatisfactory conditions are perceived to exist and certain general variables are involved in the definition.

CHART I

A TYPOLOGY OF PROBLEMS**

| | CALCULABLE | INCALCULABLE |
|---|---|---|
| SPECIFIED | I SIMPLE PROBLEM | III COMPLEX PROBLEM |
| UNSPECIFIED (i.e. open ended) | II COMPOUND PROBLEM | IV METAPROBLEM |

*Source: T.J. Cartwright, "Problems, Solutions and Strategies: A Contribution to the Theory and Practice of Planning," Journal of the American Institute of Planning, May 1973, pp 179-187.

**Source: T.J. Cartwright, "Problems, Solutions, and Strategies: A Contribution to the Theory and Practice of Planning," Journal of the American Institute of Planning, May 1973, p 183.

An example of the problem typology can illustrate the multiple problem definitions. The general problem is transportation from Lexington, Kentucky to Washington, D.C.:

- As a simple problem it might be: The distance from Lexington, Kentucky to Washington, D.C. is five hundred miles by car.

- As a compound problem it might be: The distance from Lexington, Kentucky to Washington, D.C. is five hundred miles by car. Travel time depends upon weather conditions, road conditions, the time of day one travels and other factors.

- As a complex problem it might be: One may travel from Lexington, Kentucky to Washington, D.C. by car, bus or airplane.

- As a metaproblem it might be: Travel from Lexington, Kentucky to Washington, D.C. is difficult and expensive because Lexington, Kentucky is of moderate size and does not have many of the benefits of multiple airlines and train transportation characteristic of a larger city.

Some examples from the health sector further illustrate the utility of the problem typology. Hospitals face many problems because of shifts in federal and state coverage for Medicaid. University hospitals are especially vulnerable in some states. Cartwright's typology can be applied to different levels of problem definition in a hospital planning problem.

Some of the problem definitions meet the general specifications for strategic planning, while others are examples of tactical planning. Explicit and implicit value choices are evident in the following examples.

EXAMPLE I

MEDICAID CRISIS FOR A UNIVERSITY HOSPITAL

GENERAL CONDITIONS:

- 27% OF THE INCOME FOR THE HOSPITAL HAS HISTORICALLY COME FROM MEDICAID PATIENTS.

- STATE POLICY HAS REDUCED COVERAGE OF MEDICAID PATIENTS, AND A PROJECTED DEFICIT OF $2 MILLION DOLLARS CAN BE ANTICIPATED IN THE NEXT YEAR'S BUDGET.

- BUDGET PROJECTIONS INDICATE THAT THE HOSPITAL WILL GO BANKRUPT IN THREE YEARS UNLESS SIGNIFICANT ACTION IS TAKEN.

EXAMPLE II

I. SIMPLE PROBLEM - INSUFFICIENT INCOME FROM 70% OF MEDICAID PATIENTS TO COVER COSTS; NEED TO CONSTRUCT A STATISTICAL MODEL BASED ON NUMBERS OF TYPES OF MEDICAID PATIENTS THAT SHOULD BE ADMITTED TO REDUCE THE HOSPITAL'S LOSSES BY 35% IN NEXT YEAR

II. COMPOUND PROBLEM

KNOWNS

1. STATISTICAL MODEL BASED ON "SIMPLE" PROBLEM

2. DESIGN OF AN ADMISSIONS PROCEDURE BASED ON STATISTICAL MODEL THAT INCLUDES:

   A. REQUIRED CARE CLASSIFIED BY EMERGENT, URGENT, OR ELECTIVE CARE

   B. FINANCIAL ANALYSIS OF ALL CASES AND REJECTION OF ELECTIVE CASES FOR WHICH COVERAGE IS NOT AVAILABLE

UNKNOWNS

1. EXTENT STATISTICAL MODEL APPLIED TO ADMISSIONS PROCEDURE WILL PRODUCE DESIRED CHANGE

2. REACTIONS OF PATIENTS, PHYSICIANS AND COMMUNITY

III. COMPLEX PROBLEM

MAJOR VARIABLES

- NEED TO REDUCE MEDICAID POPULATION SERVED BY HOSPITAL OVER THE NEXT YEAR AND THE NEXT FIVE YEARS
- POTENTIAL FOR MARKETING TO A WIDER POPULATION GROUP THAN CURRENTLY SERVED BY THE HOSPITAL OVER NEXT FIVE YEARS
- POLITICAL FEASIBILITY OF INCREASED SUPPLEMENT FROM STATE TO COVER MEDICAID POPULATION IN UNIVERSITY HOSPITAL OVER NEXT TWO YEARS

IV. METAPROBLEM (IMPRECISE BUT PROFOUND)

- ARE THE ADJUSTMENTS REQUIRED TO DEAL WITH THE MEDICAID CRISIS CONSISTENT WITH THE UNIVERSITY HOSPITAL'S MISSION?
- ARE THE PROBLEMS SUFFICIENTLY IMPORTANT THAT THE MISSION OF THE UNIVERSITY HOSPITAL SHOULD BE RE-EXAMINED?
- WHAT SHOULD BE THE HOSPITAL'S MISSION FIVE YEARS FROM NOW?

A central theme of Cartwright's conceptual framework is that each of the problem types has a corresponding form of analysis and limits on action. His conceptual model is illustrated in Chart II.

He further indicates that the nature of the problem has implications for overall strategy of plan development and implementation. For example, simple problems fit the comprehensive rational model most closely. Compound problems lead to a mixture of comprehensive and rational approaches.

For teaching purposes one may establish the basic typology of problems in any of a number of courses--such as institutional and community planning, multi-hospital systems and inter-organizational relationships, health services management or planning, and administrative techniques. Depending on the course, the instructor may wish to add other dimensions to the typology before proceeding to plan development and plan implementation. This is illustrated in Chart III.

CHART II

LIMITS OF ANALYSIS AND ACTION BY TYPE OF PROBLEM*

| Type of Problem | Limits of Analysis | Limits of Action |
|---|---|---|
| I. Simple (a specified number of calculable variables) | Complete understanding of all of the variables (comprehensive analysis) | Maximization or optimization |
| II. Compound (an unspecified number of calculable variables) | Complete understanding of some of the variables (in-depth analysis of subproblems) | Suboptimization (second best, "satisficing", etc.) |
| III. Complex (a specified number of incalculable variables) | Partial understanding of all of the variables (quick surveys) | Overall Improvements (Pareto "suboptima") |
| IV. Metaproblem (an unspecified number of incalculable variables) | Partial understanding of some of the variables (points of departure, benchmarks, etc.) | Partial improvements (Pareto "suboptima") |

*Source: T.J. Cartwright, "Problems, Solutions and Strategies: A Contribution to the Theory and Practice of Planning," Journal of the American Institute of Planning, May 1973, p 184.

CHART III

PLANNING PROCESS
(Who participates in the planning process and what are the rules? At the individual institution? As part of a multi-hospital system?)

PROBLEM DEFINITION | PLAN DEVELOPMENT | PLAN IMPLEMENTATION

PLANNING AND ACTION STRATEGIES
(Rational, Incremental, Mixed Scanning and Radical)

The next example is based upon what might initially be defined as a problem of nursing absenteeism, but the problem is shown to be linked to other significant issues of nursing recruitment and retention. The example might be used in a course on health services administration. It has both strategical and tactical planning components which are interwoven in the problem definitions. The examples should be particularly helpful in illustrating:

1. the need to develop planning as a way of thinking for an entire hospital, and

2. the multiple administrative roles within a hospital and their interdependency in the planning process.

The example especially illustrates the benefits of analysis of a problem at various levels of an organization. The definitions in the example complement each other. Examples could also be cited in which multiple definitions compete or substitute for each other. To a limited extent the example also illustrates the sequencing of problem definitions and the hospital's interface with its environment.

EXAMPLE III-A

NURSING ABSENTEEISM

GENERAL CONDITION:

20% OF THE TOTAL NURSING STAFF MISSED TWO DAYS OF WORK EACH MONTH DURING THE PERIOD OF NOVEMBER THROUGH FEBRUARY.

EXAMPLE III-B

"NURSING ABSENTEEISM DEFINED AS A METAPROBLEM"
BOARD

PROBLEM DEFINITION AND ANALYSIS (IMPRECISE)

A. MANY OF THE BOARD MEMBERS SUSPECT THAT AN INDIVIDUAL'S PATTERN OF ABSENTEEISM MAY BE USED AS A PREDICTOR OF INDIVIDUALS WHO MAY LEAVE THE HOSPITAL IN THE NEAR FUTURE.

B. A NURSING SHORTAGE EXISTS IN OUR COMMUNITY. WE MUST FIND CREATIVE WAYS OF RECRUITING AND RETAINING NURSING STAFF.

ACTION

1. WE ARE BEGINNING TO BECOME CONCERNED WITH HOSPITAL'S CAPACITY TO ATTRACT AND RETAIN QUALIFIED NURSES. CREATIVE APPROACHES TO THIS ISSUE SHOULD BE EXPLORED WITH SPECIFIC ATTENTION TO ABSENTEEISM.

2. A FIVE-YEAR PLAN FOR RECRUITMENT AND RETENTION OF NURSES SHOULD BE DEVELOPED WITHIN THE NEXT SIX MONTHS.

EXAMPLE III-C

"NURSING ABSENTEEISM DEFINED AS A COMPLEX PROBLEM"
DIRECTOR OF NURSING

PROBLEM DEFINITION AND ANALYSIS (VARIABLES IDENTIFIED)

A. 20% OF THE TOTAL NURSING STAFF MISSED TWO DAYS WORK EACH MONTH DURING THE PERIOD OF NOVEMBER THROUGH FEBRUARY.

B. MAJOR PROBLEMS IDENTIFIED THROUGH DISCUSSION WITH NURSE SUPERVISORS AND HEAD NURSES INCLUDE:

   1. DISSATISFACTION WITH THE WORKING ENVIRONMENT

   2. FEELING A LACK OF FULFILLMENT WITH NURSING AS A CAREER

   3. UNSATISFACTORY ARRANGEMENTS FOR MAINTAINING RESPONSIBILITIES AT HOME AND WORK SIMULTANEOUSLY.

C. FURTHER ANALYSIS OF THE PROBLEM IS NEEDED.

ACTION

1. NURSING ADMINISTRATION WILL DEVELOP AN IMMEDIATE PLAN OF ACTION WHICH INCLUDES ATTENTION TO THE WORKING ENVIRONMENT, CAREER SATISFACTION AND PERSONAL RESPONSIBILITY FOR DEVELOPING SATISFACTORY ARRANGEMENTS FOR CHILD CARE.

2. ATTENTION WILL ALSO BE GIVEN TO A MORE PRECISE DEFINITION OF THE PROBLEM AND TARGET GROUPS NEEDING "SUPPORT SERVICES."

3. A FIVE-YEAR PLAN WILL BE DEVELOPED BY NURSING ADMINISTRATION WITH STRATEGIES FOR RECRUITMENT AND RETENTION OF NURSES. THE PLAN WILL BE COMPLETED IN SIX MONTHS.

EXAMPLE III-D

"NURSING ABSENTEEISM DEFINED AS A COMPOUND PROBLEM"
NURSING ADMINISTRATION/HOSPITAL ADMINISTRATION

PROBLEM DEFINITION AND ANALYSIS (CALCULABLE VARIABLES AND INCALCULABLE VARIABLES)

KNOWNS

A. 20% OF THE TOTAL NURSING STAFF MISSED TWO DAYS WORK EACH MONTH DURING THE PERIOD OF NOVEMBER THROUGH FEBRUARY.

(NEW DATA)

B. 25% OF THE NURSING STAFF ARE BETWEEN 22-30 YEARS OF AGE AND HAVE SCHOOL-AGE CHILDREN.

C. 80% (OF THE 25% OF THE NURSING STAFF WHO ARE BETWEEN 22-30 YEARS OF AGE AND HAVE SCHOOL-AGE CHILDREN) MISSED AT LEAST TWO DAYS OF WORK EACH MONTH DURING THE PERIOD OF NOVEMBER THROUGH FEBRUARY.

D. SURVEY DATA INDICATES THAT 90% OF ABSENTEEISM IN THE GROUP (22-30 YEARS OF AGE WITH SCHOOL-AGE CHILDREN) IS RELATED TO TWO PROBLEM AREAS: SATISFACTORY ARRANGMENTS FOR THEIR CHILDREN WHEN THEY ARE ILL, AND WORKING ON THE DAY SHIFT. THE REMAINING 10% WERE ACCOUNTED FOR BY A VARIETY OF CAUSES. (MIX OF KNOWNS AND UNKNOWNS)

PROBLEM DEFINITION AND ACTION

ATTENTION SHOULD BE GIVEN TO CREATIVE "SUPPORT SERVICES" FOR MOTHERS BETWEEN 22-30 YEARS OF AGE WITH SCHOOL-AGE CHILDREN, INCLUDING: SCHEDULING OF SHIFTS ENCOURAGING PERSONAL RESPONSIBILITY FOR SATISFACTORY CHILD CARE ARRANGEMENTS, AND DEVELOPING SEMINARS ON INTEGRATION OF PROFESSIONAL AND PERSONAL LIFESTYLES FOR WORKING MOTHERS WHO ARE NURSES.

EXAMPLE III-E

"NURSING ABSENTEEISM DEFINED AS A SIMPLE PROBLEM"
NURSE SUPERVISORS AND HEAD NURSES

PROBLEM DEFINITION AND ANALYSIS (CALCULABLE VARIABLES)

A. 20% OF THE NURSING STAFF MISSED TWO DAYS OF WORK EACH MONTH DURING THE PERIOD OF NOVEMBER THROUGH FEBRUARY.

B. FURTHER STUDY INDICATES:

25% OF THE NURSING STAFF ARE BETWEEN 22-30 YEARS OF AGE AND HAVE SCHOOL-AGE CHILDREN.

C. 80% (OF THE 25% OF THE NURSING STAFF WHO ARE BETWEEN 22-30 YEARS OF AGE AND HAVE SCHOOL-AGE CHILDREN) MISSED AT LEAST TWO DAYS OF WORK EACH MONTH DURING THE PERIOD OF NOVEMBER THROUGH FEBRUARY. THIS GROUP OF NURSES IS A "TARGET GROUP" FOR FURTHER STUDY AND "SUPPORT SERVICES."

ACTION

1. PRIORITY SHOULD BE GIVEN TO MONITORING ABSENCES AMONG "TARGET GROUP" BY COLLECING DATA ON ABSENCES BY CAUSE OVER THE NEXT YEAR.

2. A GROUP TO RECEIVE SPECIAL "SUPPORT SERVICES" AND A CONTROL GROUP FROM THE TARGET GROUP CAN BE IDENTIFIED. THE IMPACT OF THE INTERVENTION CAN BE EVALUATED BASED ON ABSENTEEISM RATES IN THE SAME TIME PERIOD NEXT YEAR.

CONCLUSIONS

Based on the analysis of Cartwright and the author's own thoughts, the following conclusions are suggested content of Chart IV.

Strategic planning is both an art and a science. Value determination as a critical component of strategic planning continues to be more of an art than a science. A more systematic understanding of problem definition can potentially contribute to more effective achievement of strategic planning's potential.

CHART IV

1. PROBLEM DEFINITIONS CHOSEN FOR THE DEVELOPMENT AND IMPLEMENTATION OF STRATEGIC PLANS ARE FUNDAMENTALLY SUBJECTIVE.

2. PROBLEMS ARE NOT CONCRETE REALITIES; THEY ARE PERCEPTIONS OF REALITY.

3. CONDITIONS BECOME PROBLEMS WHEN SOME OF THEIR ATTRIBUTES ARE LABELED AS UNDESIRABLE.

4. PROBLEMS MAY BE DEFINED ON A RANGE FROM PRECISE TO BROAD. A PRECISE PROBLEM DEFINITION IS NOT NECESSARILY MORE SCIENTIFIC THAN A BROAD DEFINITION. THIS VARIES BY THE NATURE OF THE PROBLEM.

5. PROBLEM DEFINITIONS DETERMINE THE KIND OF ANALYSIS, NATURE OF SOLUTIONS, AND STRATEGIES FOR IMPLEMENTATION.

6. THE NEEDS OF STRATEGIC PLANNING, INCLUDING THE PROBABILITY OF IMPLEMENTING A SOLUTION, MAY IN SOME INSTANCES BE SERVED BY A PRECISE DEFINITION AND IN OTHERS BY A BROADER DEFINITION. THIS VARIES BY THE NATURE OF THE PROBLEM, SOPHISTICATION OF ANALYSIS TECHNIQUES, AND ACCEPTABLE STRATEGIES OF IMPLEMENTATION.

7. SIGNIFICANT ISSUES FREQUENTLY MAY BE ANALYZED AS A CLUSTER OF PROBLEMS WHICH MAY BE DEFINED IN MULTIPLE WAYS. THESE DEFINITIONS MAY COMPLEMENT, COMPETE OR SUBSTITUTE FOR EACH OTHER.

RESPONSE

by Scott A. Mason
President
National Health Advisors, Ltd.

Dr. Berry has made a number of useful observations regarding the importance of problem definition to the overall strategic planning process in his paper "Problem Definitions and the Strategic Planning Process for Hospital and Health Services Organizations." It is clear, though perhaps not obvious, that basic value determinations underlie the entire strategic planning process. I was somewhat struck that it would seem that such values might be the only stable aspect to an otherwise volatile and turbulent process that attempts to take stock of a particular uncertain environment insofar as health care is concerned.

An underlying value that the author has brought to his article is the premise that cost containment is the major concern of the 1980s. Of course, "cost containment" is really a euphemism for productivity. I suggest that, among practicing administrators, cost containment may well have been displaced by competition now as the major concern of the 1980s.

The focus of Dr. Berry's article is that problem definition is a fundamental component of value determination; and further that, as such, problem definition can greatly influence the process of strategic planning. He suggests at one point that "the process for strategic planning varies significantly by problems or opportunities." I would be more inclined to suggest that the analysis might vary considerably on that basis, but that the process remains somewhat generalized. A distinction is made at several points between strategic and tactical planning. At one point, the author suggests that "strategic planning may form the framework for tactical planning..."; I would suggest that, at least from a normative standpoint, strategic planning should in fact form the framework for tactical planning.

I was particularly taken by a comment made by Dr. Berry that strategic planning had to be "grounded in history and existing constraints." I think, to some degree, this is the essence of value determination insofar as the strategic planning process is concerned. It seems doubtful for most non-profit hospitals in the U.S. that many of the fundamental values underlying their growth and development have been altered over the years. Perhaps this is not the case in recent times, where marketing and competition have taken on heightened importance; however, I suggest that until several years ago planning specialists had to be particularly mindful of the history of the organization--which, while providing some understanding of the values underlying the development of the organization, also provided certain limitations and constraints with respect to kinds of strategies that could be embraced by the organization. These same historical constraints in values truly reinforce the author's statement that the ideal and practice vary.

Dr. Berry speaks to two dimensions of a problem, substantive and process. I must confess that it is not clear to me how these vary in particular. Had Dr. Berry said substantive and perceptual dimensions, I would

have no difficulty (having lived in Washington most of my life) separating these dimensions, as they are typical of the political arena. As an example, one could suggest that the Reagan Administration's pro-competitive approach to health care involves very little in the substantive realm and quite a lot in the perceptual realm (generally different to each listener).

Like Dr. Berry, I found T.J. Cartwright's article "Problems, Solutions and Strategies: A Contribution to the Theory and Practice of Planning" to be of interest. I confess that it was not readily apparent to me which type of problems would lend themselves to tactical vs. strategic planning, only in that I don't necessarily feel that a given problem definition is that dependent on short-run vs. long-run parameters. Cartwright speaks of four types of problems, as Dr. Berry has indicated, differing on the basis of the number of variables and the precision of specificity involved. The lack of specificity can perhaps be related to uncertainty, which logically increases with the time horizon involved. In this context, the less specified problems (i.e., compound problems and metaproblems) would logically seem to be more long-run.

It seems to me that the essential value of the value determination process is in the development of decision rules for selecting among alternate strategies. The purpose of value determination, then, is to make explicit what has previously been largely implicit in the decision rules that have been made by a health organization.

As an example of this, I was involved in the development of a strategic plan for a large multi-hospital system. Part of this analysis involved the review of a specific program that was losing on the order of $500,000-$750,000 a year. Evaluating this in light of financial criteria resulted in a rather clear decision; however, there were other values involved in the program that weren't entirely obvious to the analyst. For this reason, the analyst's recommendation to drop the program in favor of something else fell on deaf ears. The analyst's recommendation may have been entirely correct from a strategic, business point of view, but only in the absence of certain other values that others felt were of equal or more importance. This example merely supports the statement by Dr. Berry that "problems aren't objective realities but rather perceptions based on the values, knowledge and skills of the analyst."

From a teaching standpoint, I agree that problem definition could be useful. I should share my bias with regard to multi-institutional management in saying that, while I believe certain skills from managing single institutions are indeed transferable to multi-institutional management, I also believe there are unique skills required of such managers.

In that context, I suggest that problem definition would be a particularly useful component of any course on multi-hospital or multi-institutional systems. For example, recognizing the difference that multiple variables can make to the definition of a problem would seem most appropriate. In addition, precision and specification of problems are likely to be inherently more difficult to such multiple organizations, and therefore the study of problem definition can impart to the student an appreciation of the complexity that is generally inherent in planning for such facilities.

This will also reinforce, I believe, the limits of analysis and limits of action that are practical in such situations; the analyst is always in need of more than he can obtain in the way of data and specificity.

In closing, the author notes that strategic planning remains both an art and a science. With respect to value determination, it clearly remains more the former than the latter.

# ENVIRONMENTAL SCANNING AND BOUNDARY SPANNING AS EXTERNAL VALUE DETERMINATION MECHANISMS

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The problem of value determination as used in the formulation of hospital strategy is a relevant concern to organization decision-makers for both the proper assessment of environment threats and opportunitites, and the development and implementation of effective long-range strategies. Berry's paper discussed the importance of values to the conceptualization and definition of problems as part of a rational approach to decision-making, liked to the development of strategies and their implementation. Another area in which the determination of value is important is in the environmental scanning and boundary spanning activites of hospital executives.

## Environmental Scanning

If the environment is critical to the open systems concept of organizations, then one would suspect that scanning of the environment in order to keep up with its dynamic nature would be equally critical to the planning of successful strategies and performance. There is very little literature on scanning (Pfeffer and Salancik, 1978) and little evidence that much scanning activity actually takes place (Fahey and King, 1977; Thomas, 1980). One problem facing organiztions is that managers are restricted in their search activities by what Simon (1967) called "bounded rationality." This concept states that managers are forced to restrict their information processing activities because the human mind can only process and use a limited amount of information at one time. This bounded rationality forces managers to focus their search activitities or limit inplut, thereby reducing comprehensiveness or rationality in decision-making.

Radford (1978) summarized several theories of scanning or search activities by stating that search is motivated, simple-minded and biased. It is motivated because it is usually begun in response to a certain stimulus and stopped when an apparent answer is found, as opposed to the notion that scanning is routine or continuous. A search is simple-minded because it is directed toward the symptoms of problems, rather than the problems themselves; and biased because it is usually undertaken to support previously-held theories or to support decisions which have been all but approved and implemented. Search is also biased because it deperds on the training mindset of those doing the scanning, as well as on organizational policies and procedures.

Knight and McDaniel (1979) also stated that human processors are subject to selective and situational constraints as they receive and process information. In addition, distortion of information occurs due to the environment, previous experience and present state of being. Obviously, these constraints are subject to the value systems--the "spectacles"—through which information processors view their environments.

An additional problem for consideration when viewing the external environment of organizations is the identification of the appropriate environmental problems or issues for the policy-maker to address. The objective environment of the organization is the "real" environment that exists outside the organization. The perceived environment of the organization is that set of environmental elements which the manager or decision-maker "perceives" to exist outside the organization.

Bourgeois (1980) noted that the issue surrounding the distinction between objective and perceived environements is both a philosophical and methodological question. The philosophical argument discussed by Bourgeois addresses the question of what is more important to organizational behavior or performance: the real or objective environment, or that environment which the decision-maker perceives as the environment. The methodologist's question would deal with how the researcher would treat this question in studying organization behavior. How does the researcher identify the differences, if any, that may exist between these two constructs and how might those differences affect outcome?

Child's (1972) strategice-choice and Weick's (1969) enactment represent concepts which view the conscious decisions that organizations make to work within one or more aspects of the environment when developing organization strategy. Their concepts state that it is through a stream of decisions, or through identification with environmental elements, that the perceived environment becomes objective, at least to the focal organization. The enactment of an envionment reflects the environmental scanner's inherent value systems as operationalized by the selection of problems or issues in the environment felt to be relevant, or of importance or value, to the formulation of strategy.

## Boundary Spanning

Certain individuals in the organization are more closely linked to the external environment than others. It is these individuals that transmit information both from the organization to the environment and from the environment back to the organization. These people are said to occupy boundary spanning roles because their influence and activity spheres are external--beyond the organization's typical boundary. In the hospital, this might include the top management team, the Board of Trustees, the medical staff and other key people who deal constantly with the hospital's customers, suppliers, competitors or regulators (the task environment).

As information processors, boundary spanners serve a key function: that of being informational "gatekeepers" to the organization. This role obviously has the capacity to filter information to detect unknown or shifting value systems in the environment, as well as to filter and disseminate information in accordance with the organization's values or the boundary spanner's personal values and goals. As such, the hospital's policy-makers must understand this potentially powerful position and assess information both from the context of the environment and the information transmitter.

## Strategy Formulation Process

The strategy formulation process in organizations has been viewed from two basic perspectives. The first perspective includes both objectives and strategies (ends and means) in this process (Chandler, 1962; Uyterhoeven, Ackerman and Rosenblum, 1977); the second perspective separates goal (objective) formulation form strategy formulation (Ansoff, 1965; Ackoff, 1970; Richard, 1978; Grant and King, 1979). This latter perspective recognizes that the processes of setting organizational objectives, and then further refining strategies to obtain these objectives, are--while sometimes very closely-related or even intertwining--separate. An additional question on strategy formulation which remains unsolved is whether the process is analytical (Grant and King, 1979) or whether strategy is formulated through a political/behavioral/process (Braybrooke and Lindblom, 1970; Allison, 1971; MacMillan, 1978; Bower and Doz, 1979).

The formulation of strategy is generally felt, however, to encompass several steps strategy identification (current); environmental analysis; resource analysis; gap analysis; strategic alternatives; strategy evaluation (future options); and strategic choic (Hofer and Schendel, 1978). These steps provide a format from which the organization can evaluate its present strategy, assess the opportunites and threats from the external environment, and analyze corporate resource strengths weaknesses in order to select workable strategies for attaining organizational objectives. Additionally, it is necessary to include an examination of key decision-makers' values and the firm's social responsibilities when evaluating strategy alternatives. Stratgey formulation is then the process for developing organizational strategies derived from the examination of ways to implement corporate objectives and policies.

As can be seen from the following two models of strategy formulation, the values of the organization's top management must be considered when developing implementable strategies (see Figures I and II). It is very important for organizations to accept the role that personal values have in strategy formulation and implementation. Obviously, the effective hospital strategy must be put into action by the hospital's managers; without considering their personal values and goals, as well as those values extant in the external environment, successful strategies will not ensue.

## Conclusions

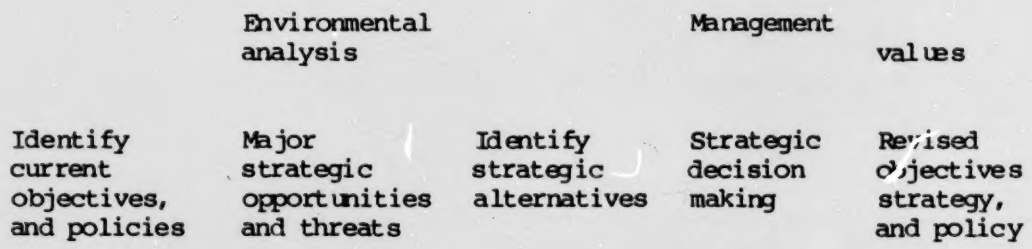
Rohrer (1978) stated:

> In the context of individuals or corporate strategic choice, behavior channeling would be manifest in the generation and testing of action alternatives, problem-solving and other aspects of decision-making. Values act as perceptual screens in the choice, filtering and interpretating decision-relevant date (p. 13).

The combination of effective use of environmental scanning, boundary scanning roles, and internal problem conceptualization and definition can assist in strategy formulation and implementation only if the impact of values is understood and taken into consideration. Value determination, therefore, is an important concept to develop in the curricula offered in graduate programs designed to train future health care leaders. Because hospitals operate in such a complex and turbulent environment, decision skills which intertwine problem-definition skills with an appreciation for the need to effectively adapt to changing environmental conditions and values will be critical.

Figure I

Andrew's Model of Strategy Formulation Process




SOURCE: Hofer and Schendel, Strategy Formulation: Analytical Concepts, West Publishing Company, 1978, pg 48.

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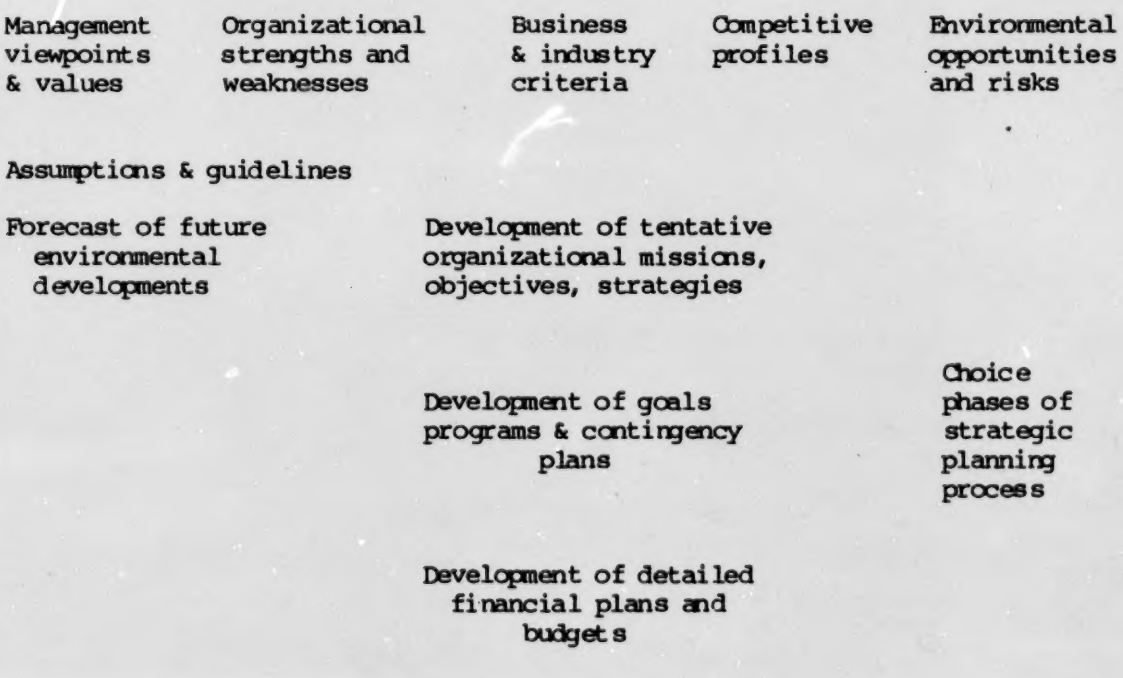
FIGURE II


Management viewpoints & values
Organizational strengths and weaknesses
Business & industry criteria
Competitive profiles
Environmental opportunities and risks
Assumptions & guidelines
Forecast of future environmental developments
Development of tentative organizational missions, objectives, strategies
Development of goals programs & contingency plans
Choice phases of strategic planning process
Development of detailed financial plans and budgets

SOURCE: King and Cleland, Strategic Planning and Policy, Van Nostrand Reinhold Company, 1978, pg 76.

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# DEVELOPING A STRATEGIC PLAN

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The historical development of strategic planning in management academia differs significantly from the development in the health care field. Strategic planning in health care appears to be an outgrowth of the traditional health planning process. Health planning initially focused on facilities development; it expanded to include program or service development and evaluation, and now has come to consider market, competitive and regulatory factors, among others. As with traditional health planning, it has more closely approximated strategic planning as it would be defined in a school of management.

The managerial (i.e., management school) approach to strategic planning stresses the following:

- It requires recognition and analysis of all factors affecting the organization;
- It requires the predication of how and how much each of these factors will affect the organization; and
- It requires the development of a coherent strategy which will address all these factors so as to maximize the success of the organization.

## Curriculum Context

Much current emphasis in strategic planning, whether at ITT or at Hospital Corporation of America, seems to be on marketing. This is not particularly surprising, as it is often difficult to know where the formulation of marketing strategy ends and strategic planning begins. As a result, much of the responsibility for teaching strategic planning in the Health Care Management Program (a section of the M.B.A. program) at Boston University lies within the marketing course, one of many required functional courses.

Various aspects of strategic planning, however, are taught throughout the whole curriculum. Because strategic planning is seen as having major financial components, aspects of it are taught in the finance and accounting courses. The same may be said about the courses in economics, operations management, organizational behavior, and management policy. Thus, total responsibility for a strategic planning module does not lie specifically within any one course or department but is spread, albeit unevenly, throughout the school, relying most heavily on marketing and management policy courses.

## Theoretical Support for the Concept of Strategic Planning

As a result of teaching varying aspects of strategic planning throughout the functional areas of the school, the theories underlying the concept of strategic planning are as diverse as are the functions themselves. The finance course's module on the capital asset pricing model provides theoretical underpinning for strategic planning, as does the organizational behavior course's module on integration and differentiation, the labor relations course module on power theory, and so on.

While all forms of management theory contribute to the teaching of strategic planning, however, a significant theoretical base has existed for more than a decade in the form of corporate strategy theory. Literature such as Strategy and Structure: Chapters in the History of the American Industrial Enterprise by Alfred Chandler (Cambridge, MA: MIT Press, 1962) and Corporate Strategy by H. Igor Ansoff (New York: McGraw-Hill Book Company, 1965) preceded and fostered the birth of the newer literature on strategic planning. This newer literature includes sources such as Defining the Business: The Starting Point of Strategic Planning by Derek F. Abell (Englewood Cliffs, NJ: Prentice-Hall, 1979) and Strategy Formulation: Analytical Concepts by Charles W. Hofer and Dan Schendel (St. Paul, MN: West Publishing Company, 1978). These works tend to pull together the disparate sources of strategic planning theory from the various functional areas, providing a more unified view of strategic planning. Often, one or more of these readings are assigned in the required management policy and/or marketing courses. It should be noted that many of these books rely heavily on marketing concepts and theories. This once again places the responsibility for addressing strategic planning more heavily in the marketing area, as well as the management policy area, than throughout the remainder of the school.

## Content and Methods

The basic framework on which much of the teaching of strategic planning rests is a model which assumes the following:

Opportunities Objectives Strategy Structure Systems

This approach takes a positive view toward strategic planning, even under the most difficult of conditions, by focusing on current and near-future opportunities. (Problems tend to be viewed as the underside of opportunities.) The opportunities presented at any point in time are the most current of the model variables. As one gets farther to the right in the model, the greater the probability of the variable being out of date and less well-adapted to the current environment. Thus, Philip Kotler in Marketing for Nonprofit Organizations (Englewood Cliffs, NJ; Prentice-Hall, 1982) suggests the following (pp 77):

| Opportunities | Objectives | Strategy | Structure | Systems |
|---|---|---|---|---|
| 1982 | 1979 | 1975 | 1972 | 1969 |

Part of the method of teaching strategic planning is to have students analyze the fit between the model variables and the current opportunities available to the organization. The intent is to have the students recognize that the greater the lag time between objectives, strategy, structure and

systems matching current opportunities, the less adaptive is the organization--and the less likely it is to succeed.

Through the various M.B.A. courses, the students are asked to examine the ability of the organization to adapt to its opportunities. They look at:

1. Organization Size - very large organizations, for example, are prone to bureaucracy which makes them less adaptive;

2. Organization Resources - the greater the organization's resources (whether financial, managerial, technological or other), the more able it is to adapt and the greater are its options;

3. Organizational Leadership - the personalities and professionalism of the organization's leadership as well as the tone of the organization's "culture" can seriously aid or hinder the organization's adaptability; and

4. Organizational Constraints - the greater the organizational constraints (whether labor, political, regulatory, reimbursement, legal, clinical or otherwise), the less the organization is able to adapt to its current opportunities.

Throughout the M.B.A. program, the students are taught how to analyze and manipulate management variables, such as those in the basic strategic planning model. A brief but more in-depth examination of these variables is provided.

Opportunity analysis is composed of two parts: environmental (external) analysis and resource (internal) analysis.

Environmental

If good strategic planning and implementation results in an adaptive organization, then a major strategic planning focus is: to what must the organization adapt? The environment is analyzed from all reasonable relevant perspectives in terms of the threats and opportunities it poses to the organization. These perspectives include:

| | | |
|---|---|---|
| political | regulatory | labor and management |
| legal | reimbursement | sociological |
| economic | competitive | clinical |
| cultural | market | |
| behavioral | technological | |

Moreover, the nature of the environmental change, which causes the organization to have to adapt, is examined. Noted are four states of environmental change:

1. Stable and unchanging - this is almost unheard of in the health care field and is rarely discussed;

2. Stable with minor fluctuations - this is found in a limited number of health care settings and is discussed when those situations arise.

3. Slowly changing in a predictable fashion - this environment is common in a variety of settings like maternity hospitals and nursing homes and extended care facilities where changes in the demographic market are predictable and unavoidable. The students are faced often with this type of environmental change.

4. Rapidly changing in an unpredictable fashion - this is the most common of environmental changes in health care, due to regulatory, reimbursement, political and economic factors. Students are frequently confronted with this type of environment in the course of the M.B.A. program.

Students are taught about environmental changes and forces, and are expected to be able to recognize and analyze their effect upon the organization.

Resource analysis

The identification of an organization's strengths, weaknesses and distinctive competences are an inherent part of any organizational analysis, whether for strategic planning or some other purpose. In this area, the contribution of the different management functions can be easily identified.

1. Finance and accounting - teaches the analysis and use of financial resources, including such topics as debt/equity analysis, financial strength, relationships with financial institutions, and institutional investment strategies.

2. Marketing - while heavily used in the environmental analysis to assess the various external publics and markets, also used to help the institution identify the market's views of its strengths and weaknesses through the use of market research.

3. Operations management - teaches the student to analyze and develop efficiency and effectiveness in the production process (whether it be the production of goods or services).

4. Organizational behavior - examines issues such as the breadth, depth and flexibility of management; the effect of organization structure and design; and formal vs. informal power structures.

Objectives and goal formulation

Virtually every required M.B.A. course (except the computer course) discusses the mission, objectives and goals of an organization as the starting point for functional analysis and strategy development. A general management definition of these terms are:

mission: the organization's basic purpose, what it is trying to accomplish;

objectives: the major variables which the organization chooses to emphasize and pursue, such as profitability, market share, census, or general reputation;

goals: objectives made specific with regard to magnitude, time and who is responsible.

By requiring students to go beyond developing general mission statements to the development of specific goals, the M.B.A. program forces the student to avoid a grocery list of gratuitous recommendations which, when taken together, do not form a coherent strategy. Instead, the necessary specificity required in the formulation of goals moves the student closer to developing strategic capabilities.

Strategy formulation

Strategy formulation is a major task of every required course (except the computer course). In addition to functional strategy (marketing strategy, financial strategy, organizational design strategy, etc.), cross-functional strategy models are introduced and used in many courses. Examples of this are:

1. The product portfolio matrix - which examines products and services according to their relative market share and market growth. The portfolio brings up issues of risk, cross-subsidization of products/services, cash generations and cash use, the cost of growth and product line relationships. The limits to the usefulness of this model are also discussed.

2. The General Electric strategic business planning grid - which suggests that organizations should select the markets in which they compete on the basis of market attractiveness and organizational strength.

3. The product/market expansion model - which raises issues of vertical integration, both forward and backward; horizontal integration, such as shared services, contract management, acquisition and merger; diversification; and gaining control of key production resources.

Structure and organizational design

One particular management function, organizational behavior, is most closely associated with this variable; however, discussions regarding this variable commonly arise in marketing, operations management and management policy courses as well. Basic issues of management structure, personnel policies, and "corporate culture" are included in this variable.

Systems design

This involves educating the student to the need for (as well as the development of) information, planning and control systems in all the functional areas. As students specialize in their second year of the M.B.A. program, they may become well-versed in systems design in at least one functional area.

Application and Techniques

The theory of strategic planning is taught traditionally, through the use of texts, articles and lectures. However, the process of developing a

strategic plan is addressed in a more active hands-on approach through heavy use of the case method in all functional courses. The intent of the case method is to make the students apply what they have learned in a real-life situation. (Cases are in fact recent real-life situations facing managers, put down on paper for teaching purposes.) Because most of the cases are recent, students are exposed to contemporary management situations which are similar to the ones they will face when they graduate.

The case method requires not only analysis, but also strategy development. The constant practice which the M.B.A. students receive in developing strategy as part of the case method makes them relatively adept at developing strategy in general, whether for a specific functional strategy or for a strategic plan. Strategic planning cases appear in all the functional courses but tend to be concentrated in the marketing and management policy courses.

Future Changes

Because no one functional area holds full responsibility for strategic planning, nor is there a well-defined strategic planning module as yet, it would be reasonable to anticipate that a more organized approach to strategic planning might be developed. The two functions likeliest to claim it and offer it a home are marketing and management policy. These two functions are constantly stepping on each other's toes already with regard to who should teach what; strategic planning is one more topic to add to this hotly contested list. Regardless of which function inherits the formal rights to strategic planning, if either one does, the responsibility to teach M.B.A. students to engage in strategic planning will always be viewed as an all-school responsibility due to the relevance across all management functions of strategic planning.

RESPONSE

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The best way to introduce my remarks about Dr. Clarke's description of the strategic planning aspects of the M.B.A. program at Boston University is to ask Dr. Clarke if I have missed the Fall 1982 application deadline yet. Conceptually, the curricular module is complete and well-integrated. From the hands-on emphasis Dr. Clarke described discussing the application and techniques, it seems practically useful and meaningfully challenging. Nevertheless, I would like to offer a brief staccato of comments for your consideration from three perspectives--theory, experience, and the market.

- First, I don't appreciate the strategic planning-marketing identity crisis. I see the two as highly interrelated in a complex way, but indistinguishable.

- I would echo Dr. Clarke's statement that the total responsibility for a strategic planning module does not lie specifically within any one course or department.

- The "opportunities" and "strategy" elements of the strategic planning framework Dr. Clarke used deserve some special attention.

  -- Borrowing a very simple model of the management process from Leavitt, strategic planning is a function with substantial footing in all three major parts of the management process. Certainly, analysis and decision-making are at the heart of any M.B.A. or health administration education program, but has enough room been left for the other two elements--path-finding and implementation? (Figure 1)

  -- Opportunity analysis and strategy formulation seem to be path-finding tasks. As such, I suggest that they especially benefit from (if they are not substantially dependent on) insightfulness, intuition, synthesis, and creativity. Are management and administration programs addressing such skills?

  -- To the extent that the role of values and value determination are being included in the educational process, some of these elements are being addressed. Are we addressing them adequately? How do we or how can we teach creativity? How can we expand the "boundary of rationality"? Is it enough to focus on the decision analysis techniques or is there room for expansion into these other areas?

- The implementation function of management is relevant to the strategic planner, too. Even the strategic planning process must be implemented and the interrelationship between planning and doing ideally resides in each well-developed manager.

-- In this regard, the human side of the enterprise comes to the forefront. People, people, and more people are a very large part of what implementation is about. Group dynamics, human psychology, social psychology, listening skills, communication skills, organization development--all of those "interpersonal skills" everyone talks about--may deserve much more attention in general management education in strategic planning tracts.

-- Borrowing from human resources management, categories often recommended as needing specification in selecting the right person include intelligence and "learnability," experience and knowledge, motivation, and personality characteristics.

  - Experience and knowledge are certainly a major focus of educational efforts. (Figure 2)

  - Is enough being done to help people learn how to learn for a lifetime?

  - Is enough being done to help people understand what motivates them?

  - Is enough being done to help people understand the dimensions and resultant variety of individual personalities and to understand their own specific personality using Meyers-Briggs or other tools?

Although all I've said so far may be based on nothing but personal biases and quirks even though I have included it under theory, I would like to make just a few comments that more directly reflect my experience.

- Dr. Clarke mentioned the examination of organizational leadership as an indicator of the organization's ability to adapt. Specifically, she mentioned the tone of the organization's culture. While I am sure it is not widely true everywhere, I assure you that there are still some health-related institutions where the culture is a blend of protectionism, antagonism and noncommunication. There are still a few health care delivery organizations in which the attitude of the physicians is: "Just hang out the sign and the patients will naturally flock to us."

- I looked back over my own experiences to try to identify the enhancements I now would like to have seen in education based on my experience. I would seek enhancements of skills for dealing with the five P's: PEOPLE, POLITICS, PEOPLE, POWER, and PEOPLE.

I'd like to quickly turn to my third and final perspective, the market. I will focus on a portion of the market for strategic planners. What I am about to offer is perhaps at best an indication or some food for thought. It is not, as you will quickly see, the result of sophisticated market research. The basis for the information I'll present is a survey of employment ads during the period November 1981 to April 1982 from three sources--The Wall Street Journal, The New York Times, and The Society for Hospital Planning Employment Flyer.

There were seventeen ads in the health field and thirty-one ads in other fields or a total of forty-eight ads seeking planners of some type. I'm in trouble already with small numbers. I'm also in trouble because I'm making observations that can be highly influenced by writing ability. I also haven't tested for statistical significance or pursued other scientific minimums. Let me proceed, and if nothing else, the colors may look nice.

- Graduate education was usually required. Obviously, the data don't indicate that the health field is somewhat more degree conscious, but it is tempting to infer. Thank goodness for AUPHA's sake that it is not strongly the other way around. (Figure 3)

- The next chart on years of experience clearly suggests that if a firm or institution uses the big name papers, they are looking for more senior staff. It also shows that two-thirds of all the ads were seeking planners with three or more year's experience but only 15 percent were for more than five years of experience. (Figure 4)

- With regard to type of experience, two categories were used--marketing experience and consulting experience. (Figure 5)

  -- One-third of all the ads for planners were seeking marketing experience.

  -- Nearly twice the percentage of non-health ads sought such experience as did the health ads.

  -- Only 15 percent of all ads mentioned consulting experience.

  -- More than twice the percentage of health ads sought consulting experience (25 percent) as the percentage of other ads (10 percent).

- I tried to examine the general skills being sought and used three categories: communications, analytical and conceptual, and interpersonal skills. (Figure 6)

  -- Twenty-one percent of all ads mentioned communication skills; and 23 percent mentioned analytical and conceptual skills, but only 8 percent mentioned interpersonal skills. So much for my experience, perhaps!

  -- There were a cluster of knowledge areas and background related to mergers, acquisitions, and divestitures that was mentioned in 16 percent of the non-health ads but did not appear at all in the health ads. We either still don't talk about such things with full openness in health care, or recruiting institutions sense that the experience just isn't out there yet. (Figure 7)

  -- Slightly less than 20 percent of all ads for planners mentioned finance and business knowledge, reflecting some bridging of the gap between two formerly more separate areas. However, only half the percentage of health ads did (11 percent) as did the non-health (23 percent).

-- Other skills and knowledge areas that were mentioned among the health ads were:

| | |
|---|---|
| 1 - OD | 1 - Behavioral Sciences |
| 2 - Facilities | 1 - OR |
| 1 - Health Economics | |

-- Information systems skills in the form of DP skills or system design skills were mentioned in two health care ads and in six non-health care ads.

Obviously these charts and percentages have little value as a basis for anything but brief reflection. However, the specific categories and requirements appearing in ads for planning personnel just may be of some interest.

I'd like to close by referring to Dr. Clarke's closing comments on future change. I, too, view strategic planning as an all-functions responsibility. I, too, hope it does not get captured by any one function or subject area--not even my own M.B.A. field of marketing.

# PLAN IMPLEMENTATION

by Robert C. Myrtle, D.P.A.
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Our course on institutional planning is designed to provide students with the basic knowledge, skills and techniques used in the institutional planning process. As a result, the learning objectives include the following:

- to understand the legal and organizational requirements of health planning;
- to demonstrate an understanding of the key steps in the planning process;
- to be able to use several different methods for assessing community and service area needs;
- to be able to critically evaluate current health facility services and programs;
- to be able to develop a program for the delivery of health services; and
- to be able to construct a system for managing the program development and implementation processes.

To ensure that these learning outcomes are realized, students are actively involved in solving planning problems, applying basic methods or evaluating actual applications through the use of case studies and problem or situation analyses; and are exposed to presentations by expert practitioners in the field.

The course is designed around fifteen different elements dealing with different aspects of the planning process. These include:

- The Legal Requirements for Planning
- Planning as Organizational Change
- Organization and Processes for Planning
- Understanding and Determining Your Service Area
- Medical Staff Analyses
- Program Analyses
- Community Analyses

- Impact Assessments
- Establishment of Mission, Roles, Goals and Objectives
- Development of Service Delivery Programs
- Facility Planning
- Financial Analysis
- Addressing CON Requirements
- Management of Project Implementation
- Marketing as an Implementation Strategy

Organizational and Program Change: The Bottom Line of Planning

Our view of plan implementation is one of planned and deliberately managed organizational change. As such, successful implementation depends both upon the technology for structuring and managing plan implementation, and upon the processes that are developed for ensuring that planning leads to implementation that leads to change. For this reason, this course tends to emphasize the process aspects of plan implementation more than it does the more traditional structural techniques for managing and controlling the conversion of plans to actions.

Theories Which Guide Our View of Implementation

The theories which guide our view of implementation are drawn from literature generally categorized as "organizational and inter-organizational relations." This literature suggests that to understand organizational change (implementation in this case) one must understand the intra- and inter-organizational dynamics which influence and are influenced by organizational activities. Successful plan implementation requires open systems thinking, an appreciation of intra- and inter-organizational dynamics, and a basic understanding of community institutions and community power structures as well as the strategies, tactics, and techniques for using these to help the health care organization in restructuring its task domain and to reposition itself in its environment.

Methods, Techniques and Applications

The foundation for implementation begins with the development of a sensitivity to the profound influence that power and politics have on an organization and its activities. To develop this awareness we draw heavily on literature resources and focused presentations by consultants and expert practitioners in the field. Of particular interest is how they diagnose or assess the political power structures of organizations they have worked with and the important role that this knowledge plays in their structuring or managing of the planning and implementation processes. Usually this module is brought to a close by having students apply the concepts raised in the literature and the presentations to an organization that the class is fairly familiar with and to have the consultants and practitioners react to these assessments.

Viewing implementation as a process of organizational change requires that some attention be devoted to structures, strategies and processes for gaining the support of key constituencies of the organization. One frequently used vehicle is the process of involvement and participation in the planning activities; however, the development and formation of committees, task forces or work teams is not something that is done casually. Considerable deliberation and structuring is required to ensure that the function of the committee is directed towards task-relevant purposes.

To sharpen the student's skills in the processes of committee formation and management, we have developed a brief exercise on selecting the membership of a health care institution's planning committee. Through this process students begin to develop their skills in critically assessing the issues of committee membership and performance. More importantly, the involvement of experts from the field to comment on students' efforts often leads to additional insights into the process.

Understanding the inter-organizational contexts of plan implementation is achieved through the use of several different case studies which emphasize different aspects of the community: its needs, institutions and political power structures. In addition, particular attention is devoted to understanding the strengths, weaknesses, and task domains of key institutions and organizations in the community and their relationship to the current and potential activities of the organization conducting the strategic analysis. Particularly important is the issue of how what you are doing or propose to do may impact on the domains, structures and interactions of the significant members of the organization's task and social systems environment.

Up to this point the emphasis on plan implementation has been "strategic" in its orientation. As the plan emerges and organizational adoption occurs, the issue of implementation becomes far more focused. At this point some of the more traditional concerns of implementation are addressed, including the CON process, the use of marketing as an implementation tool, and the development of a managerial system for overseeing the implementation effort.

We approach the legal aspects of plan implementation first because of the need to address CON issues. Implementation in this context becomes a question of structuring and managing the CON review process to ensure prompt and fair assessment of the proposed changes. Emphasis is placed on understanding the process and procedural requirements of the law as well as acquiring an appreciation of the "politics" of CON reviews. To facilitate this process, we have developed a series of brief case scenarios which are given to students to analyze and to select the response which is legally and procedurally acceptable. Then, by using the actual hearing materials from which the case scenarios were drawn, a discussion of the findings and the students' responses is undertaken. Often this session is conducted by an attorney specializing in health law, although on several occasions the Director of Review for the local HSA has conducted the discussion.

The next aspect of implementation is one which focuses on the development of a management system to ensure that the plans and programs that are adopted are actually implemented. The role of responsibility matrices, task assignments, budgeting procedures and the linking of implementation outcomes

to organizational reward mechanisms are discussed. Likewise the use of managerial tools like Gantt charts, CPM and PERT methods are discussed and their application in the implementation illustrated.

The final aspect of implementation is in the context of marketing. Since we offer a specific course on marketing, the intention here is to show how plan implementation and marketing are mutually supportive activities, and thus that marketing issues must be given particular attention in the plan development process.

## Possible Changes in the Curriculum

Naturally the comments and suggestions that emerge from those reviewing our notions of implementation will be considered in our future revisions of the course content. Nonetheless there are two areas where we have some discomfort and thus feel some need to strengthen or resolve. These are the extent of the emphasis on strategic planning and the development of a more generic set of planning concepts. Taking the first issue last, one particular concern that we have is the specificity of content to hospital issues. While this focus meets the needs of many of our students, others who work in ambulatory care settings, long-term care facilities or health maintenance organizations do not get quite the same benefit. The issue then becomes how to make the content more applicable to a variety of health care institutions while maintaining the specificity students demand. Ideas or suggestions for resolving this issue would be appreciated.

The second issue is finding the appropriate emphasis on the strategic aspects of planning, particularly as it pertains to alternate organizational arrangements. Here the literature on health care planning is quite limited, and the material available in the business literature is not generally applicable to the health care context (or if it is, it requires some conceptual flexibility to make the translation). The issue of how to strategically position yourself vis-a-vis others in the environment is scarcely addressed in the literature or through case examples. Perhaps this issue is not as important as it seems to us, but from our vantage point most health planning is not as strategic in its orientation as the changing environment seems to suggest it should be. Any reaction or suggestions for dealing with this issue would also be appreciated.

## Summary

To us it is difficult to separate planning from implementing. While many of the concepts we have described as implementation activities can be seen as planning activities, our particular view provides the emphasis that we report. In our opinion implementation begins with the planning process. Within this context all planning activities are constantly being assessed by their implementation feasibility (or desirability); thus it is incumbent upon us to provide students with the models and methods for dealing with planning in this context. Perhaps this explains our open systems view of the planning-implementing cycle and the emphasis we place on intra- and inter-organizational processes and activities. Awareness of these dynamics and the ability to use this knowledge in the development of plans and implementation strategies seems to be one of the basic ingredients for ensuring that the adopted policies become the enacted policies.

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RESPONSE

by Douglas R. Brown, Ph.D.

Bob Myrtle's eclectic behavioral approach to teaching hospital strategic planning--which stresses open systems management change, participation, power and politics, strategies and tactics as well as rational analysis--makes a great deal of sense to me. Accordingly, the course is designed to integrate and apply the students' knowledge and skills perhaps more than to develop basic knowledge and techniques. (I am assuming that the students have already been exposed to basic courses in organizational behavior, accounting and finance, operations management, microeconomics, and marketing). If so then the course probably should be scheduled in the students' last semester and taught by someone who has acquired experience/research in the field as well as a reasonable grasp of underlying disciplines and techniques.

Methods: Cases, role playing, student presentations, consultant and practitioner reactor panels, field projects and similar devices plus "mini-lectures" by the instructor seem to be appropriate. The more the student is placed in "real situations" with realistic hard and soft data, the better.

Curriculum fit: My bias is to include long-range planning as a central component of strategic management which also encompasses the management of operations (the internal stuff). Strategic planning, then, focuses on the external environment and makes the critical link with internal program development, etc. Do not interpret this to mean that strategic planning doesn't have to involve folks down in the organization - as every practicing administrator knows, this is crucial.

Marketing: The overlap (perhaps eighty percent) and relationships between marketing and planning are obvious and no longer worth debating, in my view - it becomes a useless semantic hassle. I did detect in Bob Myrtle's outline an emphasis on the implementation (and promotional?) side of marketing rather than the diagnostic (consumer analysis) side. Both are important. In addition, I would place market planning and financial planning under long-range strategic planning.

Business literature: As for background knowledge from long-range planning in business, I have found the work of Steiner and Naylor (Planning Executives Institute Research Series) to be the most helpful. On the whole, however, the literature has definite limitations for the health field and, quite frankly, I doubt that it has been very useful to business either.

Problems: The lack of good cases has been a severe problem in trying to teach such a course, but they are coming along, mainly developed by management consultants providing institutes on strategic planning (several recently sponsored by the Society for Hospital Planning). The emphasis on hospital issues

doesn't bother me too much since this continues to be where the "action" is and the "lessons" are applicable. Moreover, perspectives on sites such as HMOs will come along in time. I agree with Bob that approaches to "strategic positioning" are important and think that market attractiveness analysis, crude as it may be, is useful and fun to apply.

Other considerations: The application of political strategy formulation (e.g., MacMillan) is intriguing. I have been amazed at how sophisticated some hospitals are becoming in political action planning which sets out in great detail the what/who/how/where/when kinds of strategies designed to get results--for example, in CON transactions. Dealing more effectively with the external environment means that managers will have to sharpen their negotiation skills (if there wasn't reason already with increased collective bargaining and professional competitiveness). A planning course offers an excellent opportunity for strengthening these concepts and skills.

Multi-hospital systems development, diversification, etc.: This development, an extremely significant trend in the industry, can also be highlighted in the course, again emphasizing the process aspects rather than structural matters which can become too detailed.

Ultimately, I think this or some other course in the curriculum must come to grips in an applied way with the ethical implications of "behavioral technology" and results of it. Powerful tools are available to manipulate people and the configuration of the industry, in ways not dreamed of only a few years ago. How we teach these techniques troubles me deeply and I expect it troubles you as well. I hope the first paper dealing with values will address this issue.

RESPONSE

by Martin B. Gerowitz, Ph.D.
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One would think that a view of plan implementation as one of planned and deliberately managed organizational change provides no lack of didactic opportunities, experiential information, case scenarios, and academic theories around which to develop a course syllabus on plan implementation. Yet, these opportunities create parallel sets of challenges.

A challenge in teaching plan implementation is that typically we are dealing with complex, contingent, and multivariate phenomena for which our explanations are often multicausal, tentative, conflicting, multidisciplinary and generally based on the premise that the only certainty is uncertainty.

Our students, on the other hand, are typically seeking guidance as to how they might manage more effectively in concrete situations.

- How do we bridge the gap?
- If we accept the premise that uncertainty is unavoidable, then how do we teach our students to become comfortable with this unsettling notion?
- If our theories, in theory, provide a grounding which allows our students to cope with uncertainty, then how do we teach our students to become more conscious of the importance of developing a theoretical base for analyzing and for changing organizational situations?
- How do we increase their ability to transfer their concepts and theories to familiar as well as unfamiliar situations, and more importantly, to their own organizational situations and environments at whatever level or setting they find themselves at any particular stage in their careers.

My bias is that an appreciation of theories and concepts as they relate to the issues of organizational analysis and change are enhanced when students are able to apply those concepts in real case situations using both structured and unstructured case assignments. A structured case assignment would ask questions which focus specific theoretical constructs and their components to the case situation or vignette, such as asking students for the rationale for selecting the membership of the institution's planning committee. Such case-structuring allows for both the initial acquisition of theory and the application of already acquired knowledge. This does not preclude the more unstructured or "classical" format to integrative cases later in the course or capstone seminars later in the curriculum.

There is often a tendency to focus on the answers before we define the question at hand, to ignore the process and the relationship between problem formulation and implementation. This tendency is also compounded by the fact that in complex, multi-level (i.e., corporate, business and activity level)

organizations the formulation of a business-level plan is in effect the implementation of the corporate-level strategic plan, and formulation of the activity or operational plan is in effect the implementation of the business-level plan (Lorange and Vancil, 1976).

I share Professor Myrtle's concern that the literature on institutional planning is quite limited, and the material available in the business literature not easily translated. This may be in part because the hospital as an institution is somewhat culturally bound in its organizational metaphors. The managers of hospitals did not begin to differentiate their products until the recent efforts toward external diversification through vertical and horizontal development. Despite the current popularity of the topic of diversification and case-mix management, hospitals by and large still do not internally differentiate their acute care products and services for practical management and planning purposes.

This, it may be argued, is simply a defense against the use of such information for regulatory purposes. However, regardless of the regulatory incentives and disincentives, the industry will not be able to strategically manage such case-mix portfolios unless it is capable of seeking and processing the information into intelligent decisions.

While the content and scope of Professor Myrtle's curriculum outline is indeed comprehensive, what I fail to identify is a framework capable of organizing our questions, and capable of facilitating our ability to store, organize, and retrieve relevant theories in response to these questions.

Frameworks that I have found useful for organizing decisions which surround the management of plan implementation include the behavioral science approaches to planning and problem management of Kilman (1979) in which process and structures are defined in terms of their internal and external loci. These two basic distinctions in combination create four areas of focus: external process, external structure, internal process, and internal structure.

External Structure refers to the arrangement of individuals into groups to best utilize the information-seeking and processing skills in the organization. Kilman identifies five different group design structures which may be selected depending upon the demands of the situation: ad hoc, random, personality-vested interest, task and people preference.

External Process refers to those interactions which take place between individuals once they have been assigned to various groups and intraorganizational structures. In this component of the model, questions and theories applicable to group dynamics and to the analysis and management of conflict collaboration are relevant.

Internal Process refers to the mental activities, thought processes, or loci which individuals use to work through problems. Kilman's emphasis on making one's assumptions and logic explicit is reinforced by Mason and Mitroff's (1981) notion of planning as a process of debate in which one engages in strategic assumption-making.

Internal Structure refers to various personality characteristics, styles, and preferences, related to information-seeking and information-processing tasks.

Requiring students to design their own strategic planning process, and to implement the process which they have designed in the analysis of a complex case (Montanari, 1980) helps reinforce the thesis that the planning process requires planning, structure, and management if the content of our plans are to be implemented and converted into new organizational behavior policies, procedures, and purposes.

The difficulty in identifying relevant case examples may be in part due to our failure to share the cases we have developed, discovered, or retreaded with the appropriate conceptual translations from the business literature. An AUPHA-sponsored case clearing house, workshops on case-writing, and workshops designed to share our cases and case-teaching styles might ameliorate this situation.

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